ASYMMETRIES OF POWER AND COMPETENCE AND IMPLICATIONS FOR AAC: INTERACTION BETWEEN ADULTS WITH SEVERE LEARNING DISABILITIES AND THEIR CARE STAFF.

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Abstract

This study investigates the interaction between adults with learning disabilities and their care staff. Many people with severe learning disabilities have little or no speech; for these individuals, augmentative and alternative communication (AAC) may enhance their communication. However, AAC non-use is a widely reported phenomenon. The study explores power and communicative competence within such interaction, as possible factors in AAC non-use.

An ethnographic approach was adopted; data collection was carried out in five community homes, focussing on four residents. Field notes were accompanied by video and audio recordings of natural interaction between participants. Aspects of Critical Discourse Analysis were applied to the data within the themes of turn taking, topic control, exclusion from conversation, activity exchanges, test questions and politeness; the theme of AAC was also critically scrutinized.

Findings regarding interaction between residents and staff were set in the context of the institution and of wider society. Substantial asymmetries in both communicative competence and power were evident. Staff tended to constrain interaction such that immediate participation of residents was facilitated; however, in the longer term, AAC use is likely to be thereby inhibited. Further application of critical approaches to AAC research is warranted.

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CHAPTER 1: INTRODUCTION

> "*Communication is a basic human right. Communication is the means through which we control our existence. It is the way we make friends and build relationships. It is the way we become independent and make choices. It is the way we learn. It is the way we express our feelings, thoughts and emotions. It is the way we make sense of the world around us*" (BILD undated, p1).

Introduction

As the quotation so eloquently explains, communication is central to the human experience. However, for many people with learning disabilities, communication is a major difficulty, especially for those who have little or no speech. In these cases, augmentative and alternative communication (AAC) (such as electronic aids and symbol boards) offers the promise of greatly enhanced communication. In reality, AAC non-use and abandonment are widely recognised problems.

My research explores how power relations between people with severe learning disabilities and their care staff in small residential homes may be reflected in their interaction, and examines the implications of such power relations for the use and non-use of AAC. Such settings are part of a wider societal and political context in which people with disabilities are oppressed and devalued. People with learning disabilities and limited communication are doubly disadvantaged, and one of the subtlest ways in which this occurs is through their everyday interactions (Young 1990).

Three main fields of study are pertinent to this issue of power and interaction involving people with severe learning disabilities. First is the field of communication impairment, specifically that pertaining to people with learning disabilities; second is a sociological approach to the study of disability, and the place of people with disabilities in society; and third is a political approach to the consideration of power and the disempowerment of certain groups in society. These three areas of literature are discussed in more detail in the next chapter, the Literature Review, including consideration of the concept of the institution (Goffman 1961), which made a significant contribution to the early study of the latter two areas.

Much current disability research aims to address the ethical imperative that it is conducted by people with disabilities themselves (Oliver 1992). But for many people with learning disabilities, who may be unable to "articulate and reflect upon their experiences" (Klotz 2004, p101) this is less realistic. Klotz makes a case for approaches which do not rely on eliciting data from people with learning disabilities, but which place interaction and relationships centrally, in naturalistic contextual observations. For this reason I chose to take an ethnographic approach, consistent with the view that "learning disabilities may be as much a feature of the environment and context in which people live and interact as it is about their supposedly innate cognitive and communicative abilities " (van der Gaag and Dormandy 1993, p217). Chapter 3 describes in detail the methodology of the study, paying particular attention to the ethical and practical issues raised by research of this nature.

My analysis centres round the hypothesis that interactions between residents and staff are characterised by asymmetries of two types: power relations and communicative competence. AAC intervention aims to enhance the latter, but this is not necessarily effective at reducing the asymmetry of the former. I suggest that asymmetrical power relations inhibit AAC use and that, conversely, lack of AAC use creates and maintains this power imbalance. It has been widely acknowledged that there is a plethora of factors affecting the success or otherwise of AAC, and yet the possibility of 'attitudes' somehow translating into discourse dynamics that do not sustain AAC has not been explored in the literature.

Context of the research project

The British Institute of Learning Disabilities (BILD) states that 50-90% of people with learning disabilities have communication difficulties (depending on the definitions used), and that 80% of people with severe learning disabilities fail to acquire effective speech (BILD undated). It is this group that may benefit from having access to augmentative methods of communication. According to the Royal College of Speech and Language Therapists,

> "Augmentative/alternative communication refers to methods of communicating which supplement or replace speech and handwriting...[for] severely communication-impaired or non-speaking individuals for whom augmentations and alternatives to speech are necessary in order to give access to the basic functions of everyday life" (RCSLT 1996, p88).

AAC refers to both unaided methods such as signing and gesture, and aided methods such as low-tech symbol cards, boards and books and high-tech communication aids that produce voice output. This project is concerned particularly with aided methods of AAC.

According to Von Tetzchner and Jensen (1996), AAC as a field came into being in the 1970s; early studies did not address dialogue and conversational interaction and analysis of this remained rare until the 1990s. They claim that "The main barrier to the development of more functional communication aids is not the state of available technology, but rather insufficient understanding of communicative and linguistic processes" (von Tetzchner and Jensen 1996, p9).

The problem of AAC non-use (or more specifically the lack of generalisation of AAC skills from instructional to natural settings (Calculator 1988)) has long been recognised as widespread and persistent. Despite this, Johnson et al. (2006) point out that there is no consensus in the literature regarding the use of such terms as abandonment and rejection of AAC systems. They distinguish between a range of scenarios such as appropriate abandonment due to regaining speech (the authors use the professionals' evaluations of appropriacy). However I am interested in situations of what Johnson et al. term inappropriate abandonment, where there is still a need for AAC, and of "partial, reluctant use of AAC" (Johnson et al. 2006, p86).

Among the many reasons for AAC non-use which have received attention in the literature, I was particularly interested in factors associated with communication

partners. They have frequently been found to use strategies that inhibit AAC use. Calculator (1988) suggested that a lack of reason to communicate, and lack of responsiveness of partners may contribute to reduced AAC use. He also identified instructional problems (e.g. emphasis on labelling), and devaluation of different modes of communication that may contribute to low levels of initiation on the part of the person with disabilities.

Training communication partners to alter their communication strategies is less well established for adults with learning disabilities than it is with children (Purcell et al. 2000). However, Owens (1997) suggests that training communication partners thereby modifying the environment may encourage AAC use. Unfortunately, as Jones et al. (1999) point out, staff turnover is a persistent issue in residential services for adults with learning disabilities (the context for my research). But even when this is not a problem, the long term use of appropriate communication skills remains problematic for communication partners.

Purcell et al. (2000) suggest that the difficulty staff have in changing their communication behaviours

> "may be symptomatic of more fundamental influences on communication...[such as] staff perceptions of their role and differences in how they view the clients. Do they see them as patients, pupils or partners? ...the prevailing ethos and the implicit priorities which management place on staff; is it to care, teach or advocate for clients?" (Purcell et al. 2000, p155).

But this "prevailing ethos" at an institutional level must surely be complemented by attention to the specifics of interaction.

In 1988 Calculator posed the question "are there generic styles of interaction which can be shown to be facilitative when interacting with a particular type of individual, when using a particular type of AAC system, for a particular purpose?" (Calculator 1988, p102). Since then our knowledge may have moved on. Twelve years later Purcell et al. suggested that "staff-client interactions in various contexts are unique occurrences that are not easily replicated across people and over time. The search for 'main effects' needs to give way to determining what works for specific staff with specific clients in specific situations" (Purcell et al. 2000, p155). Acknowledging both individual and general aspects of interaction, this thesis presents detailed examinations of interaction, within the immediate and wider institutional context, bringing a critical perspective to bear on the issue of AAC non-use.

How the project arose

In discourse analytical research such as this project, reflexivity is important since the epistemological stance of this type of research acknowledges that the researcher cannot be neutral (Taylor 2001). Indeed my identity and beliefs have influenced all stages of the research, from choice of topic to the interpretation of findings. In this section I give a brief account of some of the influences on the evolution of the project.

My professional background is as a speech and language therapist (SLT). My training and much of my subsequent practice in the National Health Service could be described as predominantly 'scientific' and much of it followed a medical model of intervention, involving diagnosis and treatment. The communication aid centre at which I worked in recent years perhaps followed these traditions slightly less rigidly. Nevertheless, the centre's work was based on a model of prescription of AAC systems, and the emphasis was on the use of technological solutions (for example, Brewster and Gregory 2002).

I and colleagues frequently observed the phenomenon of AAC non-use, but were often unable to identify practical reasons why this might be so. Adults with severe learning disabilities seemed to be amongst the least likely to benefit from our interventions. Even when the AAC provision seemed appropriate, and the individual's environment supportive, AAC might not enhance their communication significantly. I was unable to identify what was going on at a deeper level, in day to day interaction. This concern, along with my wish to carry out research as part of my professional development, led me to apply for the Ed.D. course. At this stage I was interested in investigating how beliefs held by carers about communication might be related to communication behaviours. The department that employed me did not wish to support my research in this field, so it was carried out entirely independently. This allowed me complete freedom at all stages of the project.

Given the opportunity this permitted, I wished the project to reflect my belief that communication is a human right. I therefore investigated the perspective of social justice. It is widely acknowledged that people with disabilities have experienced and

continue to experience injustice. There are two major paradigms of social justice: distribution and recognition. The first paradigm has dominated traditional analyses of social justice and the main contributor has been Rawls, who advocates the equal distribution of primary social goods unless unequal distribution advantages the least favoured (Rawls 1972). Rawls has been criticised for specifically excluding disease and disability as sources of inequality (Daniels 2003); but further, Christensen and Rizvi (1996) suggest that the distributive paradigm neglects issues of decision-making power and culture, and injustices such as cultural domination, non-recognition and disrespect, which are rooted in patterns of communication and representation.

I was also interested in the theme of power; as Byrne (2000, p105) states, "Human beings exist within a network of power relations". According to Diamond (1996) power is "not just the ability to coerce someone or to get them to do something against their will, but rather, it is the ability to interpret events and reality, and have this interpretation accepted by others" (Diamond 1996, p13). This author claims that power is consensual and open to negotiation through discourse. Although pertinent to the place of people with disabilities in society, the literature which deals with social justice and power at an individual level does not, on its own, provide tools for the detailed analysis of interaction. Also such approaches do not address situations where some participants have very limited communicative competence, and possible links with the unique circumstances surrounding AAC were not apparent to me.

During the course of my studies, I investigated the vocabulary incorporated in the AAC systems of an individual named Ralph (Brewster 2003). I explored the ways in which his vocabulary set tended to maintain or challenge traditional power relations between people with disabilities and wider society. I found evidence of both processes operating, both in terms of what vocabulary others (especially care staff) chose for Ralph, and the ways in which they responded to his use of AAC; for example, staff stated that is was not acceptable for Ralph to swear using his AAC system.

This appeared to be an example of power being exercised by one group of people over another, a situation that my professional background had not equipped me to understand. The AAC literature addresses the issue of linguistic and communicative inequality at an individual level: potential users of AAC and their naturally speaking partners do not have the same competencies within interaction. What has not been addressed in this body of literature is social inequality, enacted in discourse at the level of interaction. I therefore decided to apply these approaches to the field of AAC. "Language is not only an instrument of communication or even of knowledge, but also an instrument of power" (Bourdieu 1977, p648).

Discourse is a concept which was developed by Michel Foucault whose social theory emphasised the relationship between discourse and power and the discursive construction of knowledge. His approach was much more abstract than, but formed a basis for, Fairclough's "textually oriented discourse analysis" (Fairclough 1992b, p37). It was therefore predominantly from Fairclough's Critical Discourse Analysis

(CDA) that I selected tools with which to analyse my data (discussed in Chapter 4: Analysis).

Another strand of my thinking and reading that influenced the research was that of social constructionism. Danforth and Navarro (1998) describe social constructionism as a cluster of theoretical positions which claim "that what is assumed and understood to be objectively real...is more accurately said to be constructed...in thoughts, words and interactions" (Danforth and Navarro 1998, p31). So learning disabilities can be taken to be a social construction (conferred by professionals responsible for labelling such categories) rather than an internal condition. The theory, while consonant with a discourse approach to language, has its shortcomings. According to Klotz, "interpretations...which perceive the experience of intellectual disability as solely a product of sociocultural structures and constructions, disregard the fact that intellectual disability is also an ontological reality that makes a real difference to one's experience of being in the world" (Klotz 2004, p98). These two themes, of participants' communication impairments being a product of interaction and of the severe intellectual limitations they experience, (and the interface between the two) run through this thesis.

I chose to investigate the communication of people with severe learning disabilities who communicate intentionally but do not necessarily have a formal communication system such as speech, writing, signs or symbols. They are likely to be reliant on others to take responsibility for the success of communication, and to depend on others' skill at interpreting what may often be highly idiosyncratic behaviours. Many of these individuals live in community residential homes, and

most interaction is with the staff. Most of the older residents will have lived in large hospitals prior to their closure. Such homes seemed to me to present particular problems in the implementation of AAC; indeed the failure of hospital closures to result in the desired deinstitutionalization is discussed in the next chapter. The ethical and practical issues raised by research in these settings, are considerable and are the subject of discussion in Chapter 3: Methodology.

I carried out regular visits to five homes over the course of a year. Four residents received particular focus. Descriptions of the five homes I visited are given in Appendix 1 and profiles of the four residents I focussed on are provided at the end of Chapter 4: Analysis. Data analysis was undertaken at a variety of levels: aspects of CDA were applied to transcriptions of interaction between individuals, and drawing on extensive field notes this was set in the context of the residential homes studied, and the place of people with severe learning disabilities and services provided to them in the wider society.

Aims of the research

A concern with why non-speaking people with learning disabilities so often do not use AAC has remained throughout the development of the study. However, my ideas around applying critical dimensions through a discourse approach to language and communication took longer to crystallise. There were a number of reasons for this. The unusual (non-linguistic) nature of much of the interaction that constituted my data meant that the search for appropriate analytic tools was prolonged. Also,

discourse operates at an unconscious level (for both participants and researcher) and there was a gradual increase in my awareness of the power dimension operating within all interaction during the course of the project. There was also an unusual circularity that took time for me to recognise. In a discourse analytic approach, language may be treated as the *topic* of the study or as a *resource* for studying something else (Taylor 2001). In this investigation, language, (or rather interaction) is both topic and resource: I am interested in how power operates through interaction such that interaction does not sustain AAC use for this group of people.

What is true of ethnography generally was also true of this project, which took an ethnographic approach: "Hypotheses and research questions emerge and become refined as the study progresses" (Aubrey et al. 2000, p137). The aims of my research thus became, firstly:

To critically analyse the interaction between residents and staff in terms of power relations.

Consequent to this, an objective was to investigate whether CDA could be meaningfully applied to interaction involving non-speaking participants. Chapter 5: Findings (Part 1) presents findings according to one aspect of CDA, interactional control features (Fairclough 1992b), that ensure the smooth running of interaction, such as turn taking and topic control. This is about who controls the interaction, whether this control is negotiated, or exercised asymmetrically. I also focussed on interaction in which residents are not permitted or are not able to participate. A recurring feature of interaction was the 'test question', also drawn from CDA. Chapter 5: Findings (Part 2) explores activity exchanges (Fairclough 2003): how residents get staff to do things and vice versa. The theme of politeness is also

covered in this section. The application of critical perspectives to AAC and especially the problem of AAC non-use are discussed in Chapter 6.

The second aim was:

> **To explore the hypothesis that power relations contribute to a lack of AAC use.**

The application of this perspective to this type of interaction and its implications for AAC was not found to have received major consideration in the literature. This is the subject of Chapter 6: Findings (Part 3).

In Chapter 7: Discussion, I reflect on the extent to which these aims were achieved, and on the limitations of both this research project and of CDA in general. Unsurprisingly, the application of new perspectives to an old problem represented by this project suggests avenues for further research.

Terminology

Consistent use of terminology has been the aim throughout the thesis, and where selection of terms was not straightforward this is discussed. For ease of reference, some key terms are defined below.

Staff is used to refer to anyone working in the homes; this covers a variety of job titles such as social care worker and nurse. **Resident** was chosen to refer to those who lived at the homes; they may alternatively have been referred to as clients or service users. Although *resident* may have unfortunate connotations of institutionalisation, I wished to avoid identifying these people by their disability; my desire was to select as neutral a term as possible. It is the preferred term of an articulate user of AAC who is well known to me.

Interaction is used to include all types of interaction between residents and staff, both spoken and non-verbal. **Non-speaking** refers to individuals for whom speech is not an effective method of communication; it implies nothing about language comprehension or voice use. I use the term **communicative competence** to refer to "the quality or state of being *functionally adequate* in daily communication, or of having *sufficient knowledge, judgement, and skill* to communicate" (Light 1989, p138) (author's italics), a definition drawn from the AAC literature and discussed further in the next chapter.

Discourse, as in Fairclough's Critical Discourse Analysis, is a term that can be used in a general or particular way. In general, discourse refers to language in use or language as social practice (Fairclough 2001). Also, a discourse is a "particular

way(s) of representing some part of the (physical, social, psychological) world" (Fairclough 2003, p17); it is distinguished by its vocabulary, semantic relationships between words, metaphor, assumptions and presuppositions, grammatical features and style.

The following terms and definitions are in widespread professional usage:

Augmentative and alternative communication (AAC) "refers to methods of communicating which supplement or replace speech and handwriting...[for] severely communication-impaired or non-speaking individuals for whom augmentations and alternatives to speech are necessary in order to give access to the basic functions of everyday life" (RCSLT 1996, p88). AAC refers to both unaided methods such as signing and gesture, and aided methods such as low-tech symbol cards, boards and books and high-tech communication aids that produce voice output. This project is concerned particularly with aided methods of AAC.

Learning disability and **people with learning disabilities** are the terms adopted by the Department of Health for England and Wales and reflect current practice in UK health and social services. O'Hara and Sperlinger (1997) describe people with severe learning disabilities as having significantly sub-average intellectual functioning, in need of considerably more support than peers to participate in everyday activities such as communication, self-care, home living, social skills, use of community resources, functional academic skills, health and safety, leisure and work. Many of these individuals also have physical and sensory disabilities.

For brevity, the acronym **SLT** has been used for **speech and language therapy** or **therapist.**

The names and some descriptions of participants and locations have been changed to preserve anonymity.

CHAPTER 2: LITERATURE REVIEW

Introduction

In the previous chapter I described in broad terms the problem of AAC abandonment and non-use, particularly amongst adults with learning disabilities. I outlined relevant aspects of my personal background to help explain how I arrived at this topic of research. In this literature review, the nature of the problem and how it has been investigated by researchers so far is examined in more detail. In doing so the aim is to explore further the rationale for this research project and the approach taken to the investigation.

The review is organised around three main bodies of literature: disability, interaction and power. This research project lies within their intersection (see Figure 2:1). Within the field of disability, I am specifically interested in adults with severe learning disability who have very limited communication skills who may benefit from using AAC. Models of communication and interaction are explored in terms of what they offer to the understanding of such communication impairment. The third field, the exploration of power relations, has a significant history of application to both communication and disability; so far it has not been thoroughly applied to impaired communication nor AAC, and it is this perspective which I bring to the project. While Figure 2:1 primarily pertains to the areas of literature covered in this review, it can also be applied to the research project as a whole, the small area

identified in the centre of the diagram representing the unresearched area explored by this study.

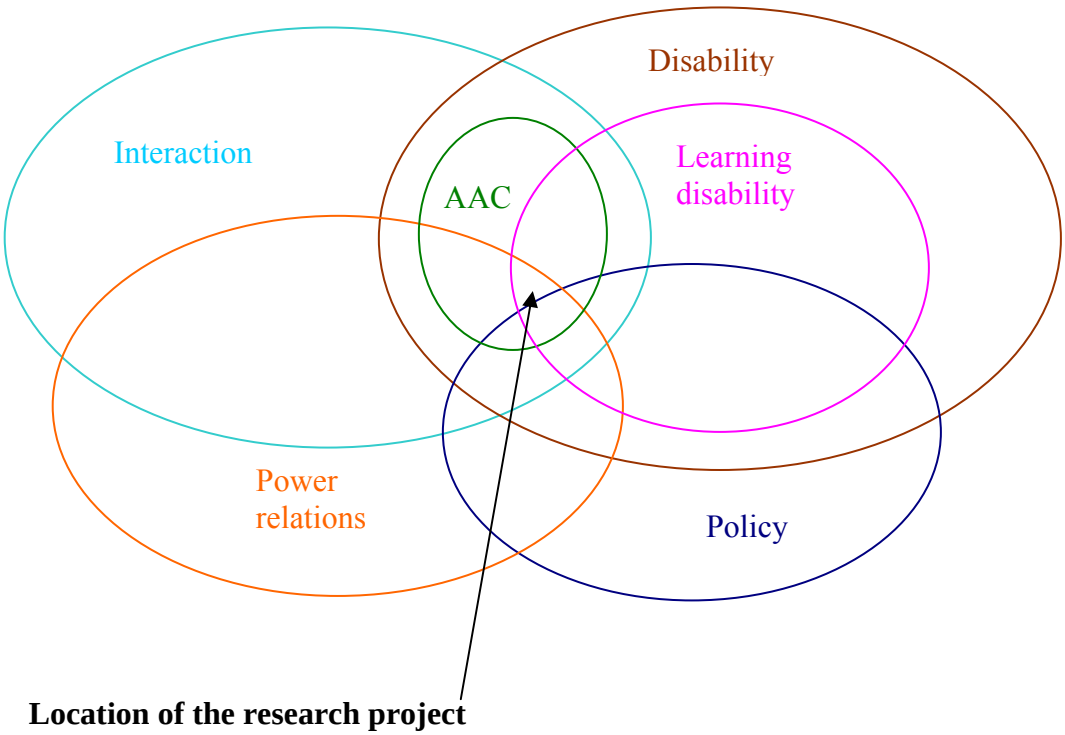

Figure 2:1. Location of the research project.

It may be observed from this literature review how few connections exist between the literature specific to the field of AAC and wider literature about communication and even disability from a socio-political perspective. According to von Tetzchner et al. (1996) "The literature in the field of augmentative and alternative communication already seems quite self-referential and narrow in focus, often citing minor authors within this field instead of authors who are central within the main literature" (von Tetzchner et al. 1996, p20). An exception to this is Warrick (1988) who applied Bronfenbrenner's ecological framework to an exploration of the influence of society's attitude to the development of socio-communicative skills of

AAC users. While status (of AAC users and of AAC systems) has received attention in the literature (von Tetzchner et al. 1996), Warrick's brief mention of power within interaction involving AAC users is not a theme that has generated a significant strand of literature in the intervening years. It is this apparent gap in our understanding that this thesis attempts to address. Another point made by von Tetzchner et al (1996) is the absence of explicit coherent theoretical models within the field of AAC, and this may also be evident from this review of the literature.

Part 1: Communication

In this section I address issues pertaining to communication that are relevant to my research. I start by explaining the stance taken towards language, which is one of language in use. I go on to explore the concept of communicative competence, and how this relates to impaired communication. I then introduce the idea of asymmetry in interaction and discuss some of the fields in which research has been carried out.

Language and communicative competence

The traditional view of language as a transparent means of transmitting meaning is now generally seen as simplistic. Language does not merely provide a neutral means of encoding and decoding information. As Taylor (2001) points out, meaning in fact changes according to the context in which it is situated. A discourse approach to language (see below) acknowledges the role of context in the creation

of meaning; discourse assumes language to be constitutive- *creating* that to which it refers. However, it can not be denied that language must still have some referential value i.e. *conveying information* about that to which it refers; so in this study, interviews are seen as providing background information that helps the interpretation or analysis of the interactional data.

Building on the idea of context being central to communication is the concept of communicative competence. This is defined in slightly different ways in the field of AAC and the wider literature. Saville-Troike's (2003) definition, from the field of the ethnography of communication is based on the work of Dell Hymes:

> "Communicative competence extends to both knowledge and expectation of who may or may not speak in certain settings, when to speak and when to remain silent, to whom one may speak, how one may talk to persons of different statuses and roles, what non-verbal behaviours are appropriate in various contexts, what the routines for turn-taking are in conversation, how to ask for and give information, how to request, how to offer or decline assistance or cooperation, how to give commands, how to enforce discipline, and the like – in short, everything involving the use of language and other communicative modalities in particular social settings." (Saville-Troike 2003, p18)

Most study of language in use presupposes that the speaker has access to an infinite number of utterances to be used in an infinite number of situations; the speaker's ability to do so 'judiciously and appropriately' is what Bourdieu (1977, p646) describes as competence; this is conceptualised within contexts of symbolic power relations between speakers and listeners.

The assumption of an adequate medium of expression, is one which cannot be made about people with severe communication impairment. Light (1989) therefore proposed a model of communicative competence specific to AAC users, rather than continue "evaluating the performances of these individuals against the benchmarks or standards of normal spoken communication" (p137). Light's definition is

> "the quality or state of being *functionally adequate* in daily communication, or of having *sufficient knowledge, judgement, and skill* to communicate" (Light 1989, p138) (author's italics).

The concept of functional communication according to Light (1989) refers to the skills needed "to initiate and maintain daily interactions within the natural environment" (p138), as opposed to settings such as the classroom or clinic.

Light's (1989) model of communicative competence comprises four components:

1. Linguistic competence, in both the native language(s) of the community and the linguistic code of the AAC system e.g. its symbols and syntax.
2. Operational competence, such as the motor and cognitive skills necessary for operating the system.
3. Social competence: "the knowledge, judgement, and skill in the social rules of communication, including both the sociolinguistic aspects and the socio-relational aspects" (p140).
4. Strategic competence: the ability to use strategies to compensate for the limitations imposed by the AAC system, e.g. to engage the help of the communication partner to construct meaning where vocabulary is limited and access slow.

If the above definition of communicative competence is compared to that of Saville-Troike, it can be seen Saville-Troike's is subsumed by Light's 'social competence'; the other three aspects of competence are unique to AAC use. The socio-relational aspects of social competence are of particular interest to me; they relate to issues of positive self-image, showing an interest in others, adopting an active role in conversation (demonstrating symmetrical patterns of turn taking), being responsive to communication partners and putting them at their ease (Light 1988). As Light points out, these are equally applicable to natural speakers, and I would add, to those with little or no speech who do not have an AAC system. However, the model does not fully address the circumstances of adults with severe learning disabilities for whom a significant role of AAC may be its use by naturally speaking partners as a receptive mode (Powell 2000) alongside speech. Furthermore, it is likely that for individuals for whom it is realistic to expect relatively low levels of competence, communication partners need to take greater responsibility for the success of communication. A further limitation of Light's model, of a more general nature, is its failure to acknowledge the inevitable power relations underlying and operating through interaction.

Asymmetry in interaction

An assumption that is generally made is the communicative competence of non-disabled people within most everyday interaction, although interaction may still be asymmetrical in terms of factors such as gender, social and economic status, age and ethnicity. Interaction between partners that also differ in their communicative competence is the subject of research in a variety of areas including child:adult

interaction, where the child may or may not have disabilities, and interaction with adults with learning disabilities both with and without speech. I briefly explore each of these in turn.

The phenomenon of 'child-directed speech' (CDS) (Pine 1994) or 'child directed language' (CDL) (Stilwell Peccei 1999) has been widely researched. Its features include simplified syntax, more repetition, greater use of questions, use of specific vocabulary, exaggerated intonation and slower speed, and a high proportion of directives. While much attention has been directed to the possibility of CDS facilitating language learning, Conti-Ramsden and Dykins (1991) point out that differences are culturally specific: some features may be facilitative, others offer no apparent advantage. Pine concludes that "There is now a general consensus that speech adjustments to young language learners are motivated by a desire to communicate rather than to teach language" (Pine 1994, p19). There may be more to it than this, however. Stilwell Peccei's (1999) examination of language and power notes similarities between CDL and language used towards elderly people. According to this author, both types of interaction may reflect stereotypical notions of children's and old people's abilities as communicators, which are thought to need to be accommodated for communication to be successful. In the case of children, CDL may enable the care giver to assert their power over the child, for example by insisting the child use socially acceptable ways of asking, as compared to the adult who is allowed to make demands. Use of questions helps the caregiver elicit interaction, but also enables them to control it; tag questions explicitly seek agreement and can therefore be seen as particularly controlling. Use of CDL with elderly people reflects the power relations between elderly people and their carers,

but can also be used deliberately to maintain them in their powerless role. In Chapters 5 and 6 similarities are also pointed out within the interaction between my participants with learning disabilities and their care staff.

Turning attention now to interaction between infants with disabilities and their mothers, we know that, amidst the variety and complexity of mother-infant interaction, amongst dyads involving babies born with disabilities, interaction patterns tend to be different from amongst dyads involving typically developing infants. For example Conti-Ramsden and Dykins (1991) have shown that the mothers of children with specific language impairment (SLI) initiate more in interaction, in order to compensate for their less able children; mothers have fewer utterances per turn, more non-informative or no responses, more directives (interrogatives and imperatives), less expansions and initiations, than mothers of 'normal' controls. The researchers compared findings from these dyads to that of their younger siblings of the same language stage and to 'normal' controls of the same language stage. They found that families have consistent styles of interaction but that "changes in maternal interaction with the SLI child [sic] are the result of specific characteristics of the impaired child affecting the mother" (p351). As noted above for CDS in general, some of these changes appear to be geared towards success in interaction. In situations of asymmetrical communicative competence, the more competent partner often adjusts their interaction style, either directly because of this limited competence, or for reasons to do with power, that will be discussed further later in this chapter. There is a considerable body of literature on the prevalence and nature of the communication difficulties experienced by people

with learning disabilities, and I return to this theme later in the chapter. At this point, I examine the broader field of learning disabilities.

Part 2: Disability

In this section I outline how disability is conceptualised in society, and how this has influenced the way services have been provided to people with learning disabilities. I then briefly describe some research about learning disabilities.

Models of disability

The traditionally dominant model of disability is often known as the medical model, according to which disability is seen as an individual problem of impairment. Associated with this are assumptions of dependency, abnormality, illness. Recent decades have seen the development of an alternative conceptualisation of disability. According to this social model "disability is a social construct created by a range of historically and culturally specific factors. It is the social and economic structures of a particular society which create disability through processes of prejudice, exclusion and discrimination" (Chappell 1998, p212).

Critiques of the social model have centred on its denial of impairment (e.g. Morris 1991) - the pain or physical limitations that cannot be eliminated by alteration of the social environment. But this evaluation, in its emphasis on the bodily experience of

disability neglects the experience of people with learning disability who have not benefited from the insights of the social model (Chappell 1998). Dewsbury et al. (2004) also draw attention to the limitations of the social model; they point out that it is a theoretical, rhetorical position and therefore replaces the privileging of one sort of professional expertise (of the medical profession for instance) with that of another- the sociologist; the social model therefore does not address the day to day experience of disabled people.

One aspect of this everyday experience is being dependent on care, which Shakespeare (2006) claims, has been neglected by much of the field of disability studies, especially the disability rights tradition. Shakespeare argues for a "pluralist approach to care and support" (p151), rather than assuming that the independent living model is suitable for everyone's needs. This need not conflict with the claim that care can be an aspect of social oppression, a view held by some theorists (Shakespeare 2006).

There are also more fundamental limitations to this social constructionist view of disability. For example, "dependency is not constructed through changing ideas; it is created by a range of economic, political, social, technological and ideological forces" (Oliver 1990, p82). Oliver therefore argues in favour of integrating social constructionism with social creationism. While both have moved away from seeing disability as entirely located within the individual, the former sees disability as being constructed in the minds of able-bodied people, enacted through attitudes and policies. Social creationism, however, locates the problem within institutional practices. The institution as a site of power relations is discussed further in Part 3.

In summary, both the constructionism of the social model and an individualistic conception of impairment, are themes which permeate my own research project, in terms of the social circumstances of exclusion and of communication impairment. I explore the first of these themes next.

Services for people with learning disabilities in the UK

People with learning disabilities are amongst the most disempowered in our society, and policies and services provided to them have often been accused of reinforcing this situation. The twentieth century saw the move from provision for people with learning disabilities in Britain being provided through segregated services in the form of large hospitals (increasingly following the dominant medical model), to delivery through care in the community. This transition was driven by cost cutting as well as humanitarian motives. Although care in the community policy was developed continuously from the 1970s onward, it was not underpinned by any clear theoretical framework. The concept of normalisation filled this gap.

Normalisation originated in Scandinavia the 1950s, and was developed by Nirje who proposed the following definition:

> "making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life of society." (Nirje 1980, p33, quoted by Emerson 1992)

From the 1970s onwards Wolfensberger further developed normalisation in North America, and the concept was later renamed Social Role Valorisation (SRV), the terms often being used interchangeably (Wolfensberger 1992). This model acknowledges the importance of how "disadvantaged people are portrayed or perceived by the public" (Emerson 1992, p5) and frames normalisation in terms of socially valued roles.

The appeal of this model is the clarity with which it suggests ways to improve the lives of devalued people. This happens through enhancing their competencies so they will be better able to fill certain valued roles, and enhancing their social image so they will be more positively perceived by others. Although SRV emphasises the integration of devalued people in mainstream society, it has been criticised, mainly for its emphasis on changing the individual, not society. O'Brien's model of the five service accomplishments was an attempt to address this, by its emphasis on recognition of individuals' needs and choices. According to this model, services should strive for: community presence, making choices, developing competence, enhancing respect, and participation, for its users with learning disabilities (O'Brien and Tyne 1981).

The emphasis O'Brien's model gives to individual quality of life and choice addresses some previous concerns but fails to acknowledge the need for people with disabilities to associate with others who share this source of oppression (Brown and Smith 1992). Furthermore, integration in the geographical sense does not necessarily eliminate social isolation, a problem described by Shakespeare (2006) as being "present in the community, but not participating in it" (p172). Care in the

community has taken the form of mini institutions (Szivos 1992) in which smaller residential settings frequently perpetuate the old institutional models of care.

During the 1990s advocacy and self-advocacy proved to be major influences on services (Race 1995), and the activities of pressure groups strengthened the voice of people with learning disabilities and those that care for them. However, meaningful participation in decisions about their own lives is a particular challenge for people with the most severe learning disabilities: choice is effectively unavailable when there is no communication (Fulcher 1995).

The Government White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century (Department of Health 2001), is the most important strategic development in the UK of recent years. It describes the prejudice and discrimination, social exclusion and marginalisation to which people with learning disabilities are vulnerable and sets out the Government's commitment to improving their life chances through four key principles: rights, independence, choice and inclusion.

While the British Institute of Learning Disabilities' (BILD's) response to Valuing People (Harris 2001) indicated that it supported these principles (and suggested a fifth, equality), it claimed that the document failed to address the complexities and practicalities of implementation. Harris pointed out that the issue of effective communication as a necessary prerequisite for an individual to exercise choice and independence received scant attention. Indeed, a subsequent review of the implementation of Valuing People suggests that people with high individual support

needs are not all benefiting from the changes brought about through Valuing People (Valuing People Support Team 2004). This report acknowledges communication difficulties as one of the possible extra problems experienced by this group and suggests in-depth communication training for supporters as one possible action to take. However, there has been progress made towards achieving the objectives within the Valuing People document; these include some people with learning disabilities feeling listened to more and living better lives (Grieg 2005). But some challenges remain; "much of the mainstream of public services has still not heard the Valuing People message" (Grieg 2005, p9). It seems that despite the progress that Valuing People undoubtedly represents, many of the ongoing issues and problems described earlier remain, especially for those people with the severest learning disabilities.

By giving a historical account of services to people with learning disabilities I hope to have demonstrated the extent to which such people are disempowered, and particularly those whose communication is limited. This is paralleled within research concerning this population, to which I now turn.

Learning Disability Research

According to Oliver (1992) "Research on disability has consistently failed to involve disabled people except as passive objects for interviews and observations" (p105). In this section I review some of the literature regarding what is variously described as 'participatory' or 'emancipatory' research involving people with

disabilities, and discuss to what extent this is a realistic goal for the individuals within my research.

Emancipatory research has political roots and arose from the necessity for the 'active and influential' (McLarty and Gibson 2000) participation of disempowered or marginalized groups in research that concerns them. In disability studies the paradigm has developed in parallel with the growing politicisation of disabled people in the late 20th Century (Chappell 2000) and the emergence of the self-advocacy movement (see above). There is currently a variety of terminology used to label research in which people with disabilities have been involved to various extents. Riddell et al. (2001) refer to this collectively as the 'democratic disability research paradigm'. Such research is collaborative, self-aware and critical. It values the contribution of those who need help to express their views, values difference and avoids recreating the traditional hierarchy within societies as a whole, as well as within the research context.

The challenges faced by this type of research are considerable. As Chappell (2000) observes, the very nature of intellectual impairment means that those experiencing it are unlikely to have the intellectual skills necessary for educational success. Further, people with disabilities will often have had few opportunities to develop the skills needed for getting involved in research, and many will have internalised the power relationships which emancipatory research seeks to challenge (Krogh and Lindsay 1999). As well as the bias towards democratic research so far having involved people with physical and/or sensory but not learning disabilities, even much

learning disability research implicitly excludes those people with severe or profound learning disabilities, and whose communication may involve little or no speech.

An exception is research by Cambridge and Forrester-Jones (2003) in which individualised methods of communication e.g. pictures, symbols and signs were used in preference to relying on purely verbal questioning. As a result, the quality of their research was enhanced by the elimination of some sampling bias, the increase in their response rates and, the researchers claim, more meaningful and reliable responses (Cambridge and Forrester-Jones 2003). For people with high support needs Jones noted that "communication was only effective in the context of knowing the individual well" (Jones 2001, p2). This takes considerable time and suggests ethnographic approaches to research. Nevertheless, care needs to be taken not to privilege the perspectives of the researcher and more articulate participants, in the ways in which data is presented.

Various methods for strengthening research of this nature appear in the literature. For example, video was used by McLarty and Gibson (2000) with people with complex and profound disabilities whose 'modes of communication…are idiosyncratic and mainly non-verbal' and often fleeting. They point out that video can enhance our understanding of such individuals because we can replay it many times, and spot nuances usually missed. Caution must be taken however, not to assume that video constitutes an objective record: it too is open to interpretation. I discuss my own use of video in Chapter 3: Methodology.

The same point may be made about transcription of interaction: when meanings may be highly ambiguous, care needs to be taken to be open about the nature of the interpretative process carried out by the researcher and (more powerful) others such as family members and carers. The literature about transcription is discussed more fully in Chapter 4: Analysis. Another possible method is to use others acting as proxy in the expression of views of an individual with limited communication (Bersani Jr 1999). However this is controversial and under-researched. Ware (2004) points out the danger of using a proxy who knows the individual well but who may be very emotionally involved, and Morris (1998) believes that information from others should be treated as additional to and not a substitute for that from people with learning disabilities themselves. The role of a proxy in my own research is discussed briefly in Chapter 3: Methodology and in more detail in Appendix 10.

The emancipatory ethos extends to the outcomes and dissemination of research findings. This too is challenging; as Thurman et al. (2005) point out, simply putting symbols on an information sheet is tokenistic, for people with high individual communication needs. Certainly the abstract theorising of concepts even if written in 'Plain English' will be out of the reach of many of those with learning disabilities. An objective of this research project, to provide feedback of my own conclusions to participants, is discussed in the final chapter.

Communication and learning disability

I now turn to the literature about communication and people with learning disabilities, and their use of AAC in particular. Also in this section, I go on to cite

some of the most relevant research findings about AAC non-use and the reasons proposed for this.

Much of the research into the communication of people with learning disabilities relates specifically to interaction with care staff, which was recognised as problematic a considerable time ago. Prior et al. (1979) for example, categorised interaction as *comment*, *instruction*, *question* and *conversation*; they found that residents were most likely to respond to conversation type staff initiations but that staff were most likely to initiate instructions, and least likely to initiate conversation, i.e. the most favourable form of interaction for promoting responses was least evident. Resident initiations were most often ignored. Using a behavioural conceptualisation of the problem, the authors proposed that this non-reinforcement may lead to extinction or decreased frequency of verbal initiations.

The importance of carer responsiveness for the development and maintenance of communication abilities is also the theme of Bartlett and Bunning's (1997) work. They found that all staff members' communication consistently overestimated the comprehension levels of participants. The authors postulated that the principles of (misinterpreted) Social Role Valorisation (see above) may be being applied by staff to their communication resulting in tension between the desire of staff to communicate in a manner appropriate to the age of the adult with learning disability, while also wanting to provide meaningful support for communication. Caution needs to be exercised in the interpretation of their results, however, since their emphasis was only on the information transfer aspect of communication in their analysis, and, as the authors acknowledged, analysis of pragmatics (how

context influences use and interpretation of language) was excluded, as was non-verbal communication. Nevertheless, the finding was replicated by Purcell et al. (1999) and Bradshaw (2001) who suggests a different reason. According to Bradshaw, the overestimation of language comprehension is thought to be because of a lack of appreciation of the role of context in supporting verbal information. However, this need not be a problem since, as Bradshaw points out, communication is never separate from context, and the people with learning disabilities will use this contextual information within communication to help comprehension.

Another recurring feature of interaction involving people with learning disabilities is an inappropriate reliance on verbal modes of communication. Purcell et al. (1999) found that staff often missed non-verbal signals, and the same group of researchers found that staff relied on verbal acts even with nonverbal clients (McConkey et al. 1999). Bradshaw's (2001) review of research also referred to a general lack of AAC use.

Communication with adults with learning disabilities shares many characteristics (e.g. one partner favouring questions and directives (McConkey 1999)) associated with other types of asymmetrical interaction such as that between mothers and their non-speaking children. Pennington and McConachie (1999) carried out research, the results of which supported previous findings regarding restricted conversation patterns between mothers and non-speaking children with physical disabilities. This is evidenced in terms of adult dominance and control in early and mid childhood. The high frequency of follow up moves by mothers means that they tend to complete the interactions, thereby adding to the asymmetry in the number of turns

taken by child and adult. In contrast, children without disabilities achieve equality in initiations by 2.5 yrs. Mothers initiated most exchanges by asking questions and issuing requests for attention or objects/activities. Indeed, the mothers issued a high proportion of directives and requests for information, especially closed questions which constrain and regulate the interaction, especially as some questions are test questions. The children tended to be responsive and compliant; they produced response moves more than anything else, such as yes/no responses and acknowledgements. It is proposed that the high levels of maternal directiveness may be a strategy since closed questions oblige a response; however, since they rely heavily on context, they may not help develop the child's conversational skills. Many of the features noted by Pennington and McConachie are discussed more fully in Chapters 5 and 6: Findings, in which I analyse my own data. A notable commonality between children and adults with learning disability, both of whom have little or no speech, is that their participation in interaction often appears to be constrained by the more able and more dominant partner to the production of highly predictable functions; such patterns fit with and therefore may contribute to the maintenance of relations of power that operate in institutional settings. This is discussed further below.

Returning to the interaction between care staff specifically and adults with learning disabilities, Sau-lai Chan and Kwau-sang Yau (2002) observed that 98% of interactions were initiated by the staff, most had neutral affect, most occurred during nursing care or feeding, and demanded the compliance of the resident. The authors concluded that psychosocial care was of lower priority than physical care. They also commented that the management philosophy demanded that high

visibility duties were carried out swiftly, leaving no time for interaction. McConkey et al. (1999) make similar points, based on their observation that clients had few opportunities to engage as equal partners. The authors raised a number of questions, for example about whether staff were aware of their communication style, and about the perceptions of staff of their own role (for example whether to care, teach or advocate) and that of the clients (for example, whether they were seen as peers or patients). McConkey et al., like Sau-lai Chan et al., noted the relevance of the values and culture of the organisation, and the need to incorporate such influences into research on staff-client communication.

McConkey et al. (1999) stopped short of discussing attitudes and beliefs of staff although this could be predicted to be relevant too. In Purcell et al.'s (1999) study, 90% of staff felt that communication could be enhanced, usually by change in the client's communication, not their own. The issue regarding changing the behaviour of the person with learning disabilities as opposed to that of their communication partner is discussed further below. Interestingly, Bartlett and Bunning (1997) found no difference in communication skills between experienced and naïve staff, suggesting that experience does not teach good practice. Mendes and Rato (1996) made a similar point regarding professionals working with children who were AAC users; staff needed to be explicitly trained in interaction strategies since these do not develop spontaneously: staff do not intuitively adapt to the child's characteristics. Banat et al. (2002) also found that more experienced staff did not make more accurate predictions regarding the comprehension levels of adults with learning disabilities, raising questions about the training provided to them. Nevertheless,

Sau-lai Chan and Kwau-sang Yau (2002) confirm that staff needed training to improve the quality of their interactions.

Adults with learning disabilities and AAC

I now move on to the use (and the non-use) of AAC, both generally, and specifically as it relates to adults with learning disabilities. To set the scene, I start by describing some features of interaction involving AAC.

Pennington and McConachie's findings concerning interaction between mothers and non-speaking children with severe disabilities confirmed the findings of previous research: natural modes (vocalization, eye gaze, gesture and body movements) are used more than AAC; the children use the quickest rather than most explicit method. The authors suggest that AAC use is rare, possibly because of lack of appropriate vocabulary, a wish to communicate like other children, or due to limitations in the child's communicative competence (see Part 1 of this chapter). One further reason is given, which is of particular relevance to my investigation: "Given the restrictions that seem to be imposed on children's interaction by their partners and the infrequent need to express novel or abstract ideas, which would necessitate the use of a formal linguistic code, limited use of aided communication systems is not unexpected" (Pennington and McConachie 1999, p395). This issue, to do with partner behaviour, is addressed more fully later in this section.

Even when AAC is used, it may be used for very few functions. In a series of articles by Udwin and Yule (1991b) on their research on children with cerebral palsy and severe language impairment and AAC, the authors found that over 80% of all utterances (in both symbol and sign media) expressed just four communicative functions. Responses to Wh- questions accounted for about half of all utterances; the other three functions were labelling (identification), action requests, and descriptions of events. Functions that were rarely used were: questions, descriptions of properties, locations and times, and reports of feeling states. Boundary markers (devices which help organise conversation), performatives (which accomplish acts by being said e.g. warnings) and evaluations were never used. A range of reasons were suggested for this narrow range of functions. Firstly, passivity and poor motivation to communicate are proposed, although it is notable that the authors do not ask why this might be the case. Secondly, the limited cognitive and social experiences of the children; thirdly are the types of communicative acts addressed to them by speaking partners; and fourthly, are the limitations of the AAC systems in terms of slow transmission rates and small vocabulary sets.

Chapter 1: Introduction gave some evidence regarding AAC often not being the communication mode of choice. Smith (1994) (in her research on children introduced to AAC before 4 years of age) identified 3 levels of factors which influence choice of mode. The first level refers to internal factors associated with the AAC user such as linguistic and operational competence and personal preferences. The second level is conversational influences e.g. partner and discourse variables such as attracting attention, novel information transfer and confirmation or denial. The third level is external factors such as partner perceptions of acceptability

of different modes, which may lead to explicit or implicit demands for a specific mode.

The lack of generalisation of AAC use from instructional to natural settings is also widely recognised. Udwin and Yule (1991) linked this with the crucial role of teachers and parents in the success of AAC programmes in school. The authors found that there was limited exposure to sign and symbol training in school, and most of it was in formal training sessions; there were few attempts to foster spontaneous use of AAC systems outside these sessions. There was also limited exposure at home, with many parents expressing reservations about the value of AAC for their child. The authors indicate that teachers and parents need to be using the systems with the child, in daily environments, otherwise "maximum generalisation and reinforcement of communicative skills cannot be assured" (Udwin and Yule 1991c, p150).

Some research into reasons for non-use has explored the views of AAC users and others. For example, Murphy et al. (1996) sought the views of adolescent and adult AAC users with cerebral palsy and their communication partners. Obstacles to effective AAC use which they identified include: lack of availability and accessibility of AAC system, partner's lack of knowledge of AAC, insufficient therapy, type of vocabulary and other modes of communication available. What this area of research does not address is the views of non-speakers who are *not* effective AAC users; this is understandable given the difficulties they would have in communicating their views. Johnson et al. (2006) surveyed the views of another group: speech and language pathologists involved in AAC provision, who identified

groups of factors they considered to contribute to long-term success or failure in AAC: support, attitude, system characteristics and fit, lack of training and maintenance/adjustment of the system. This group of professionals believed that even when the AAC system is appropriate, this is not sufficient for effective use.

Much of the AAC literature is based on research carried out with children. Although caution must be exercised in extrapolating these findings to other populations such as adults with learning disabilities, there are some grounds for doing so. Pennington and McConachie (1999) looked at non-speaking children of pre-school and school age. They observed that interaction changes little through childhood; it becomes 'fossilized'. We may tentatively suppose that this fossilization persists into adulthood. It is also worth observing that the participants in my research were in middle or early old age; their childhoods predated the existence of the field of AAC.

Another caution in the interpretation of research findings is the possibility of over-generalising. For example, Purcell et al. (2000) found that although staff prefer a directive style of communicating with adults with learning disabilities, especially non-verbal clients, changes were specific to the situation and the client. Although in general, staff have difficulty predicting and assessing their own use of communication strategies and those of others, staff may have selectively adapted their communication changes to suit the client or the context. "Staff-client interactions in various contexts are unique occurrences that are not easily replicated across people and over time. The search for 'main effects' needs to give way to determining what works for specific staff with specific clients in specific situations" (Purcell et al. 2000, p155).

So far I have emphasised a view of interaction not as an individual attribute, as it has traditionally been seen. However, this view does not seem to be reflected in AAC intervention or research. Schlosser and Lee's (2000) review of twenty years of research in AAC concludes that: "the majority of interventions aimed at changing the behaviours of AAC users rather than that of partners. Thus, even though the field has emphasized the importance of instructing partners based on the principle that communication is a transactional process [...], partner training has yet to receive the empirical attention that is commensurate with its theoretical and practical importance" (Schlosser and Lee 2000, p220).

Kent-Walsh and McNaughton (2005) responded to this. They point out that successful interaction with an individual who uses AAC relies not only on their skill but also (heavily) on the skill of the communication partner. They propose that partners can be trained to facilitate communication, but there has so far been little research on effective methods of training. Intervention directed towards partners has typically involved highly specific targets such as increasing their use of open ended questions, and yet many AAC users still observe that trained partners fail to use targeted skills.

Although difficulties in maintaining the results of partner training is an acknowledged problem, the literature generally has not gone beyond an examination of partner perceptions and attitudes, in its exploration of why their communication often does not sustain the individual's AAC use. According to Smith (1994), partner

interactional styles and attitudes towards AAC are linked to its low rate of use, but underlying reasons for this are not proposed.

Attitude research is ongoing. Recently McCarthy and Light (2005) explored attitudes towards AAC users, and suggested that negative attitudes create barriers to forming relationships, and to job and employment opportunities i.e. to full participation in society. They found that listener characteristics such as previous experience of people with disabilities, as well as measures of the communicative competence of the AAC user, were associated with attitudes. Much of the literature on attitudes is about first encounters rather than attitudes within ongoing relationships and in general it does not address the question of whether attitudes or changes in attitudes influence interaction style.

AAC research generally fails to take account of power, but when it does so it is often narrowly interpreted as control over interaction (for example, Muller and Soto (2000b) and O'Keefe and Dattilo (1992)). O'Keefe and Dattilo taught AAC users with 'mental retardation' to use a particular linguistic form (response-recode) to achieve more balanced conversation. This strategy involved responding to a question (from the naturally speaking partner) such as "what do you watch?" with a response e.g. "news" followed by a recode, like "you?". The authors claim that by teaching these individuals to not only act as respondents to their partners' initiations, the strategy enabled the AAC users to achieve greater conversational control. What seemed to me to be happening, however, was that conversational control was immediately being handed back to the speaking partner, by the use of the recode move. I do not dispute that greater balance in terms of initiation or

response and number of turns may have been achieved, but it is doubtful whether this would then be reflected in greater influence (e.g. in terms of topic) over the interaction more generally.

Part 3: Power relations

The third main area of literature relevant to this study is that of power. This intersects with both interaction and disability; but as noted above, the literature addressing severe communication impairment often adopts a very narrow conceptualisation of power as conversational control. On the other hand, sociological literature on power (for example, the seminal work of Erving Goffman in the 1960s) does not address situations in which communicative competence is as asymmetrical as that involving many people with severe learning disabilities.

Von Tetzchner and Jensen (1996) draw attention to the "predominantly behavioural orientation" within the field of AAC. In contrast, a social constructivist model of language and communication "claims that an individual's abilities do not arise from the exercise of individually possessed cognitive processes but are constructed out of the social interactions an individual is immersed in" (von Tetzchner and Jensen 1996, p1). It may be surprising that such a model is not dominant in the field of AAC, but this could account in part for why the theme of power within interaction involving AAC has received scant attention in the literature. An exception is Muller and Soto (2000b) who used an ethnographic approach to research the dynamics of

AAC use amongst adults. One of their findings was the power imbalance within conversation between AAC users and speaking partners, which the authors assert is caused by role confusion: the communication partner acts as facilitator, translator and editor. Their prompting and elaborating may alter the meaning or intent of the AAC user's message. However, the authors do not set this issue of power within conversation in wider contexts of the institution and of society as a whole. That power relations may have much wider effects, possibly influencing AAC use per se, is not an idea that has received comprehensive treatment so far.

Indeed, it could be argued that some research simply maintains power relations between people with communication impairment and natural speakers. For example, Graves (2000) considered the vocabulary needs in AAC for adults with learning difficulties. She looked at the conversational topics between staff and service users and compared published vocabulary sources such as Makaton with more flexible approaches to vocabulary selection. This research failed to acknowledge the inherent circularity within this: topics are as likely to be tailored to the available vocabulary as the other way round. Most vocabulary was found to be for the expression of needs and wants (Light 1988), (see Chapter 6: Findings), and the author suggests that this is appropriate. However, the implication of this is that interaction continues to be highly constrained and predictable, and the dependence of service users on service providers is maintained. Examples from my own data, in which residents appear to be encouraged to use a particular sign or symbol known to be available to them, are presented in Chapter 6: Findings.

Communication impairment and power

Physical impairment and communication impairment have different implications regarding the enactment of power relations between people with such impairments and those without. In today's social environment physical coercion is unacceptable; physical restraint and intervention is tightly regulated within social care environments. However there are no such controls over the discourse practices prevalent within such environments, although there are policies and guidance. In wider society power relations are increasingly being maintained by consent rather than by force (Fairclough 1992a); this happens through the social practices set up, in which the use of language enables power to be implicitly rather than explicitly exercised. Fairclough (1992) points out that professional-client interactions are becoming less formal or more conversational. While ostensibly such shifts would seem to go along with the balance of power falling less in the professional's favour, such styles of interaction enable the exercise of power to become less explicit. Clearly people who are less able to access and challenge dominant discourses, such as those with language and speech impairments, are therefore vulnerable to a much more covert and insidious form of control.

I turn now to some of the literature on power, starting with the work of eminent sociologists Pierre Bourdieu and Erving Goffman. Bourdieu took language to be not just a means of communication but also a mechanism of power. According to Thompson (1991), Bourdieu recognised the shortcomings of traditional linguistics and social science which neglected to examine how linguistic practices are linked to relations of power and inequality which characterise society. In doing so, Bourdieu emphasised the institutional aspects of language use.

> "An institution is not necessarily a particular organization – this or that family or factory, for instance – but is any relatively durable set of social relations which *endows* the individual with power, status and resources of various kinds. It is the institution, in this sense, that endows the speaker with the authority to carry out the act which his or her utterance claims to perform" (Thompson 1991, p9).

In other words, the conventions of such authority are social, not linguistic, and are sites of "conflict and struggle" (Thompson, 1991, p9). Goffman (1961) also made links between the 'total institution' and language use, suggesting that it may be characterised by staff failing to listen to or acknowledge people living in institutions ('inmates'). Goffman's contribution to sociology was much broader than this, however; it addressed the experiences of inmates (Goffman 1961) and of those recognised as being stigmatised (Goffman 1963), both still relevant today, and both of which characterise participants in this research project.

Returning now to language use, Bourdieu's (1991) concept of censorship is also of particular relevance to my research. Censorship operates in all everyday discourse and simply means that the way we speak is carefully tailored to the context (Thompson 1991). What a speaker says and how they say it is constrained by how they anticipate it to be received; this self-censorship is accompanied by censorship brought about by characteristics of the context. These ideas are discussed further in Chapters 5 and 6: Findings.

Interactions between staff and residents with learning disabilities can be seen as both everyday informal exchanges and as instances of institutional discourse. As Thompson (1991, p2) points out, according to Bourdieu "every linguistic

interaction, however personal and insignificant it may seem, bears the traces of the social structure that it both expresses and helps to reproduce." Although the situation of people with severe learning disabilities and no speech may be considered extreme in terms of their restricted communicative competence, I do not see this as a reason to suppose that the interaction in which they participate would not be subject to the same power relations as any other social encounters.

At an individual level, Renblad (2002) discusses the situation (in day centres and group homes) of some people with intellectual disabilities as one of relatively little power. Although Renblad's conclusions are not clearly supported by her data (from staff interviews), her use of Foucault's conceptualisation of power is helpful since it encompasses individual characteristics such as verbal or technical ability, which people with learning disability may be regarded as lacking. Renblad reports on the limited opportunities to exert influence on choice of activities or social contacts experienced by people with intellectual disabilities, which thereby limits their learning of the skills necessary for influencing, such as social competence. She suggests that "Increasing possibilities for communication is one way of changing the balance of power" (Renblad 2002, p279). The possibility of the converse also being true, is not proposed.

The social structure referred to above involves both the status of people with disabilities in society and that of those who care for them. Carers of people with disabilities are of low status (Shakespeare 2000); they are low paid, and often experience tensions between the needs of the care recipient and those of the bureaucracies in which they work (lack of autonomy) and often feel unable to help

those they care for. In many ways, like the people with disabilities they care for, carers are an oppressed and powerless group. Status is relative however, a fact that many people with learning disabilities would appear to be aware of.

In Hatton's review (1998) of research about the pragmatic skills of people with mild intellectual disabilities, he noted submissiveness in their interaction with people without disabilities. This is characterised by requesting permission, information or opinion of others. In contrast, when conversing with others with intellectual disability, they use more dominant strategies consistent with a perception of them as equals rather than of higher status. Such strategies are requesting attention or action, requesting information not needed by the speaker, commanding the other, direct requests, interrupting and correcting the other's utterances. Interestingly these perceptions of relative status of the conversational partner are then reflected in the conversational competence displayed by the person with intellectual disabilities. Their skills tend to be inhibited in conversations with non-disabled others who are regarded as of higher status or dominant.

Aspects of conversation such as interruptions can be seen as a strategy used by someone of high status, or as indicative of conversational incompetence. "This entanglement of competence and power in the same aspects of conversational behaviour is a potent source of misunderstanding in conversations between people with and without intellectual disabilities, where (mis)perceptions of competence and power are particularly salient" (Hatton 1998, p86). Although of central relevance to my research, it is by no means certain that the same analysis and conclusions may necessarily be applicable to people with severe learning disabilities and limited or

no verbal communication. I suggest two reasons for this; first, conversational strategies available to a non-speaker may be different and very much more limited than for their speaking partners. Second, the degree of intellectual impairment may diminish their ability to perceive interpersonal status.

Critical approaches to language

In the previous section I discussed how power and language may relate to each other. In this section I expand on this, with particular reference to critical approaches to language. These are based on the assumption that language is a social phenomenon. A key influential figure in this field was Michel Foucault, the sociologist who contributed to the development of the concept of discourse (Fairclough 1992b). Critical Discourse Analysis (CDA) is, according to Wodak and Meyer (2001), a cluster of approaches, not an empirical method, but they share similar theoretical backgrounds and are concerned with similar questions. The 'critical' component refers to its concern with social problems especially those associated with power; CDA makes a political commitment towards those who are disadvantaged. This emancipatory interest relates to my discussion of the ways in which disability has been researched (see above). "CDA aims to investigate critically social inequality as it is expressed, signalled, constituted, legitimized and so on by language use (or in discourse)" (Wodak and Meyer 2001, p2).

The term discourse has various interpretations in the literature. In Fairclough's CDA, discourse refers generally to language in use or language as social practice (Fairclough 2001); also, a discourse is a "particular way of representing some part

of the (physical, social, psychological) world" (Fairclough 2003, p17). Discourses exist at very general and at localised or specific levels of abstraction. They are distinguished by patterns of features such as their vocabulary and grammar, semantic relationships between words and metaphor, assumptions and presuppositions. Within CDA the unit of analysis is the 'text'. This refers to any instance of discourse, linguistic or otherwise.

Much CDA e.g. that of Fairclough, favours data derived from the mass media. This type of data is non-reactive, meaning that the involvement of readers or hearers in the text is distanced, both physically and temporally. Texts of this nature differ from those used by scholars such as Diamond (1996), who bases her work entirely on verbal interaction, not written texts, (although she excludes non-verbal communication and behaviour). Diamond emphasises the need for an ethnographic approach to provide the context needed to inform her interpretations of transcripts, and Fairclough confirms this: CDA is an analytical strategy which can usefully be combined with ethnography. The "micro analysis of texts" needs to be linked to the "macro analysis of how power relations work across networks of practices and structures" (Fairclough 2003, p16). In my investigation, the texts to which I have applied a form of CDA are transcripts of interaction with residents. Non-verbal behaviours have therefore been converted into linguistic form through the process of transcription. Transcripts of interviews with staff could also constitute texts although (alongside field notes derived from my ethnographic approach) I have used these to provide the necessary context. Transcription as a component of analysis is discussed more fully in Chapter 4.

Another point about the type of material to which CDA has been applied was made by Cameron (2001): much CDA is applied to institutional discourse since it tends to be ideologically significant. She indicates that face to face interactions in institutional settings are distinctive in that their aims are those of the institution rather than having interpersonal goals to do with the relationships between individuals. It is debateable whether resident – staff interactions in my investigation are most appropriately regarded as institutional or as more closely resembling other instances of personal relationships. Another way of considering this is whether the institutional context of such interactions is overridden by the uniqueness of interactions referred to by Purcell et al. (2000) (see p6). This issue is discussed further in Chapter 7: Discussion.

CDA is not seen as beyond criticism. Much of this centres on accusations of bias, because of its political agenda. It would appear to boil down to a matter of opinion as to whether or not this bias is regarded as acceptable. Fairclough points out that "there is no such thing as a complete and definitive analysis of a text" (Fairclough 2003 p14); the political stance of CDA is openly acknowledged, rather than implicit. CDA sees this lack of objectivity within a context of alternative interpretations; in interactive texts (such as in my data) the analyst's interpretations are accompanied by those of the participants since an individual's response indicates at least to some extent, how they have interpreted prior contributions to the interaction (Cameron 2001).

Various forms of discourse analysis have been applied to the field of disabilities and learning disabilities. As stated above, the starting point for CDA is a social problem,

in which CDA has an emancipatory interest (Fairclough 2001). The problem may lie within the social practice being analysed, or may be in the way that practice is represented through discourse e.g. how women are represented in the press. An example of the latter is the research of Danforth and Navarro (1998) who collected examples of discourse about learning disability from everyday life (i.e. they used language as a resource for studying how learning disability is constructed). They concluded that: "One must recognize the power of language to perpetuate devalued human identities in the speech of actors, in regard to their communicative intents and purposes" (Danforth and Navarro 1998, p42).

Scior (2003) points out that discourse analysis has been used to examine case files and has also been applied to everyday speech (such as that of professionals) in order to explore discourses about learning disabilities. However, the approach has rarely been applied to the experiences of people with learning disabilities directly, nor to their own speech. Scior (2003) did just that: the author interviewed five articulate participants (presumably with mild-moderate learning disabilities) about their identities in terms of gender and disability. The application of discourse analysis to elicited data, such as Scior's use of interviews, differs from natural (i.e. unelicited) interaction, which has received even less research attention, and this is what the current project attempts.

Conclusions

The application of discourse analysis to the interaction of people with more severe learning disabilities who may communicate predominantly non-verbally has not, to my knowledge been made. Neither do critical approaches seem to have been applied to interaction of this nature. Through textual analysis of everyday interaction between residents and staff, and contextual information to support my interpretations, I explored how asymmetries in power are evidenced in interaction patterns. My aim was to enable a reformulation of the problem of AAC non-use, one involving the dimension of power. This issue lies at the intersection between various fields of study, notably interaction, disability and power, and the location of my investigation is represented graphically in the introduction to this review of the literature. In the next chapter I discuss in detail the methodologies used and some of the challenges this raised.

CHAPTER 3: METHODOLOGY

Introduction

My research explores the idea that power relations between interaction partners might affect AAC use. I conducted case studies of small residential homes where a team of staff care for people with severe learning and other disabilities. Such settings are part of a wider societal and political context, and research is inevitably political: it can either have value to disempowered sectors of society or can maintain the status quo. People with learning disabilities and limited communication are doubly disadvantaged, and one of the subtlest ways in which this occurs is through their everyday interactions (Young 1990). I make this standpoint explicit in my research, so that this source of bias is openly identified.

My research concerns people who are, at least to an extent, unable to "articulate and reflect upon their experiences" (Klotz 2004, p101). Therefore, traditional research tools such as interviewing and life stories (van der Gaag and Dormandy 1993) are inappropriate. Klotz (2004) makes a case for approaches which do not rely on eliciting data from people with learning disabilities, but which place interaction and relationships centrally, in naturalistic contextual observations. Ethnography is therefore a valuable approach, since it recognises the "importance of context to human behaviour, and the centrality of the subjective belief systems of those involved in research to the processes and outcome of research" (Nunan 1992, p71).

It enables us to achieve insights beyond the medical, deficit model that I, as a speech and language therapist was trained in.

Conducting research in such a way that the perspectives of people with severe learning disabilities receive due attention poses significant challenges. In this chapter I consider these challenges in the context of my chosen methodology of ethnographic case study. I start with a discussion of ethical issues, then give some detail of how sites and participants were selected. The data collection methods of participant observation and interviewing are examined in some detail, including a discussion of the ways in which data were recorded. Finally, the extent of involvement of participants in the project is discussed. My methods of analysis are described in the next chapter.

Ethical issues

Ethical issues are of central concern in any research, but nowhere is this more the case than among people with limited communication skills and intellectual ability. My ethical standpoint values the experiences of participants, especially those from disempowered groups. Later in this chapter, I reflect on the extent to which I was successful in accessing the perspectives of participants with learning disabilities, and in collaborating with participants in creating data. In this section I concentrate on the more pragmatic issue of informed consent.

The homes I proposed to investigate were run by a Primary Care Trust (PCT), the local administrative unit of the National Health Service. An application was made to the Research Ethics Committee of that PCT. Unlike Clegg (2003) who argues for the necessity for a proxy for some individuals with learning disability, regarding decisions such as participation in research, the ethics committee required information sheets and consent forms for each group involved: staff, family members and residents themselves (see Appendices 2 and 3 for examples of a consent form and an information sheet). The Information Sheet for Residents followed Mencap's (2002) guidelines for accessible writing.

There are no "universally accepted standards or guidelines for establishing an individual's ability to consent to treatment" (Arscott et al. 1999, p1367), and similar issues pertain to participation in research i.e.: possession of sufficient information, capacity to make a decision and understand the consequences, and to do so free from coercion. In the absence of any objective tests, I relied on the subjective advice of the care home managers (informed by case history information). This was in line with the general ethical principles of the British Psychological Society (1991) and those more specific to adults with learning disabilities (Department of Health 2002; British Institute of Learning Disabilities 2003). None of the residents were considered able to understand either text or symbols, nor to fully understand the purpose or implications of the research, and so my Consent Form for Residents remained unused. In all cases, the resident, key worker, home manager, and (where relevant) a family member were involved in deciding whether the residents could be considered happy to participate; in Sarah's case, this was facilitated by my involvement in her multidisciplinary team meeting. The decision was always taken

after I had made several visits, and it had become clear to carers that the resident was comfortable with my presence. I clarified with those who knew the resident well what signals I should watch out for that might indicate that the resident was not happy with my presence. I gave assurances about the confidentiality of data, especially video footage, about which there was most sensitivity. On no occasion was consent refused, an encouraging response that indicated that I was considered to be trustworthy and a researcher of integrity. In practice, consent from the residents had to be assumed by default, by their failure to object, in order to proceed with the research, and the integrity of the judgement of those who signed the form was critical to this. Consent to observe and interact with the other residents was implicit in the managers' permission for me to use the home as a research site; the residents' only opportunity to withdraw this consent relied on me being receptive to any behaviour that might indicate their unease.

All staff were apparently happy to talk with me informally, and to be observed, but the majority chose to refuse consent for video recordings to be made of them; a significant proportion were also unhappy to be tape recorded. I interpreted this response as positive, in that it clearly indicated staff making their decision without coercion. I also found it disappointing; staff commented that the main reason was embarrassment and self-consciousness, and this extended to those staff who were willing to be filmed but refused to watch the film afterwards. This was not an issue for the residents who all enjoyed the attention they received when I filmed them, and enjoyed watching themselves on television. The selective granting of consent from staff resulted in significant curtailment of the amount and nature of data

collected, and the involvement of staff in subsequent perusal of those data; I viewed this as unavoidable, but I did not anticipate the extent of this selectivity.

In hindsight, I feel confident that I treated all participants with respect despite the compromises necessary for the research to proceed. None of the residents were able to give informed consent, and many of the staff gave consent based on probably a limited understanding of my research (it could be considered patronising not to allow them to take the initiative to seek further information from me, which many of them in fact did). I was disappointed that practical constraints dominated, when it came to involving participants in the research. Relationships between participants and myself were of greater value than procedures, when it came to ensuring ethical conduct, and the continued willingness of so many people to participate suggested that they did not feel exploited by me or the research.

Gaining Entry and Selection of Participants

The process of negotiating access was implicit in every visit to the field sites, but was most explicit early in the programme of fieldwork. The issues raised are closely related to those of ethics and consent, examined in the previous section. The case study approach specifically addressed the relevance of the environment to communication: it is not an individual phenomenon but a social one. My 'main units' of analysis (Yin 1994) or cases, were the five homes or field sites (see Appendix 1). At each home, 'embedded units' consisting of individual residents and staff were selected for in-depth study.

Selection of research sites

Selection of field sites was purposive (Robson 1993), in that I selected homes which I judged met the following criteria:

- Residential homes for adults with learning disabilities (maximum of six residents) in which 24 hour care is provided;
- Some residents met the selection criteria for participants (see below);
- Manager and a significant proportion of staff were willing to actively engage in the research process.

While I cannot make strong claims of representativeness of the sample, I relied on my own judgement regarding their typicality. I chose to seek only sites run by the local Primary Care Trust for two reasons. Firstly, I would need to submit only one application for ethical approval (a rather lengthy process), thereby avoiding duplication of effort. Secondly, I used to work for the PCT in question, which meant that I already had a familiarity with the administrative organisation of services.

As soon as my application for ethical approval was accepted, I approached the directorate manager of social care homes, who gave me contact details of the home managers responsible for 7 homes which were thought likely to fit my criteria. Thus access was negotiated at a number of levels in the managerial hierarchy, and this process was conducted simultaneously with the selection of sites. Each home manager handled my approach differently, ranging from informal visits, to an interview followed by attendance at a staff meeting; on each occasion, I handed out information sheets. Their appreciation of my topic as an important area in need of investigation may have been influential in the positive and enthusiastic response all

managers gave to my proposed research. Being open about my status as a speech and language therapist (SLT) recently employed by the Trust, was positive in that it lent authority to my initial approach, but required me to be clear that my research would not involve any kind of intervention or service akin to that of the SLT Department of the Trust.

I visited five homes and selected three of them for Phase 1. Visits to the other two were later commenced for Phase 2 of data collection. The number of homes and residents was decided upon in order to get a balance between depth and breadth within time constraints. *Table 3:1 Field work timeline* shows how I used my period of field work.

Burgess (1984) talks of the 'research bargain' as a way of thinking about the implications of research for participants. I viewed this bargain as being constantly renegotiated. My research bargain involved offering:

- confidentiality;
- the opportunity to offer and withdraw consent at any time;
- written and verbal information about my research;
- an approach of enquiry, not of evaluation or judgement;
- the opportunity to influence my research through involvement in the creation of data;
- any benefits of the research being indirect e.g. staff development, rather than the provision of intervention or recommendations;
- feedback about my findings, and an opportunity to discuss these before the final report and publication.

Site	Resid-ents selected for focus	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004	Jul 2004	Aug 2004
Long Lane													
Bunga-low A	Mary; Claude												
Bunga-low B	Mary												
Number 32	Sarah												
Number 34	Hilary												

Preliminary visits being made, prior to selection of research sites

Phase 1 Visits: observations and interviews ongoing

Phase 1 Visits: observations, interviews and videotaping resident-staff interactions

Phase 2 Visits: observations, interviews and videotaping resident-staff interactions

Each shaded month from October 2003 onwards consisted of roughly weekly visits, with only occasional brief lapses for holidays

Table 3:1. Field work timeline.

In return I requested:

- regular visits for up to a year;
- the scope to modify my plans as the research progressed;
- the opportunity to observe, participate in, to video and audiotape the home's activities;
- staff and residents to be willing to have me spend time with them and ask them about their views.

I found the concept of a 'bargain' helpful in maintaining an ethical stance, but the concept may give a misleading impression of equitable division of power within the research. Furthermore, practical circumstances meant that I was not entirely able to fulfil my side of the bargain, an issue upon which I reflect in the final chapter.

Selection of participants from within research sites

My selection criteria for residents were that they should:

- communicate intentionally, verbally and/or non-verbally;
- be thought (by their carers or myself) to have the potential to benefit from using augmentative or alternative methods of communication;
- be willing to participate in the research.

In my judgement, these criteria would best identify participants most likely to shed light on my research questions. Data collection centred around four specific residents (the only four for whom I obtained consent to video), who are described at the end of the next chapter.

Field relationships

The experience of negotiating initial access to the homes was encouraging, and equally positive ongoing field relationships with participants continued throughout. My presence was described by one manager as 'unobtrusive'. I divided my time between staff and residents, often sitting quietly with residents when staff were all in another room enjoying lively conversation and laughter. This gave me a sense of marginalisation, possibly parallel to that experienced by the residents, unable to participate in this side of the life of their own home. I frequently experienced the fieldworker's anxiety and loneliness that Lofland (1971) warns of, and this yielded reflections that I might not have had otherwise.

A small degree of immediate reciprocity was appropriate as my presence was possible only as a result of the goodwill of the host organisation. I frequently peeled potatoes, pushed wheelchairs, made tea, fed residents, and so on: practical contributions which tended to benefit staff more directly than residents. Simply spending time with them may have been the main benefit residents received from me. I did not feel I had much in common with most staff, except my gender; the care environment is a predominantly female one and this may have enhanced my perceived acceptability (Bailey 1996).

Data collection methods

My approach to fieldwork was ethnographic, the aim of which is to explore and understand a group of people, through the involvement of the researcher; the resultant rich description of group practices reflects the perspectives of group members (Robson 1993). I therefore employed a variety of data collection methods, in order to explore staff-resident interaction itself, and the perspectives of participants about their own interaction and the contexts in which it occurs. The two main methods used were observation (and recording) of naturally occurring behaviour, and interviews (to elicit data specifically for the research). Documentation relating to the homes in general and individual residents was also scrutinised to provide further context. The material I collected took the form of field notes, audio recordings of interviews, and video recordings of interactions between residents and staff and myself. Table 3:2 summarises these methods of recording this material, in relation to the interaction between the various groups of participants in the research.

Interaction between participants	**Residents**	**Staff**	**Researcher**	**Managers**
Residents	notes, video	notes, audio, video	notes, audio, video	notes
Staff	----------	notes	notes, audio	notes
Researcher	----------	----------	----------	notes, audio

Table 3:2. Nature of raw data derived from interaction between various groups of participants. For example, data regarding interaction between residents and staff were in the form of field notes, audio and video recordings.

The multiple data collection methods and the different sources of data permitted triangulation. This is "a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation" (Stake 2000). Triangulation theoretically enhances the credibility and dependability of the case study (Robson 1993); I discuss triangulation further in the Conclusion of this chapter.

For Phase 1, I carried out approximately 70 visits in total, to three homes, each visit lasting usually 2-3 hours, roughly weekly and spanning about seven months. Visits were discontinued when no new material or insights were arising, and when I had videoed enough interactions to get an impression of their representativeness, for those individuals. Phase 2 was commenced two months later after a period of reflection and analysis, and aimed specifically at getting video recordings of interactions between new participants. Below I discuss some of the issues raised by the various methods of data collection and recording.

Participant observation

Participant observation was an essential (but time consuming) source of contextual information and naturalistic data derived from the residents, for whom elicited data (such as interviews) were necessarily limited. Most of my time observing in the homes was spent in the public areas: kitchen, dining room and lounge, only occasionally going into residents' bedrooms, when they invited me. I made sure I was absent when my presence might be considered intrusive or an invasion of privacy. Observations were also made on various trips out, especially shopping. My

aim was to achieve ‘complexity and completeness’ (Robson 1993, p194) through informal observation, but I acknowledge the bias resulting from a reliance on me as the main instrument of data collection. Continuing visits to the research site in which none of the residents closely fitted my selection criteria (Long Lane), enabled me to develop my observation skills without adverse effect on the data derived from elsewhere.

My role was at times similar to that of the staff especially when helping with a task. However, these homes have numerous visitors, many regular and mostly there ‘on business’; my role seemed most like this. Whether viewed as staff or visitor, my relationship with residents was inevitably characterised by asymmetrical power relations, akin to that in research with children (Aubrey et al. 2000), and indeed this dimension, as evidenced through patterns of interaction, is a focal theme of my research.

My presence was not overly conspicuous, and I was generally welcomed as being a friendly and stimulating presence for the residents, being one of the few visitors specifically there to spend time with them. Being a completely passive observer would have been more obtrusive than being more involved; it seemed natural to chat with staff and residents, and not to do so would have been obvious and rude. This was how I resolved the paradox referred to by Aubrey et al. (2000) which requires the participant observer to be simultaneously passive ‘so as not to disturb the data but [also] active … recording all possible details’ (p116).

The impact of observing an individual's behaviour cannot be dismissed lightly, and is a widely acknowledged phenomenon: the observer's paradox. My strategy for minimising this effect was to spend sufficient time in each setting for participants to become used to my presence. I periodically checked with managers whether they were happy with my continued visits or if they thought there were any adverse or problematic effects; I was told of none. Further, the consistency of people's behaviour suggested that my attendance did not have a huge effect. Although the research sites are private homes, they are also relatively public: they are workplaces for staff and are frequently used for meetings involving staff based elsewhere. The observer's paradox may conceivably be less relevant for those residents who are not very self-aware; I frequently observed residents openly engaging in behaviour usually considered socially unacceptable (such as scratching their genitals), without apparent embarrassment.

My field notes were carefully organised and archived. Initial jottings were made in separate notebooks for each home, while in the field. Typed versions were completed the same day, and constituted a transformation of two different orders. Firstly, some typed notes were simply a more readable version of my jottings, including verbatim quotes; secondly, most typed notes were considerably more detailed, merely prompted by my jottings. Note taking was rarely commented on by participants. Typed notes were labelled by date, location, and all paragraphs numbered; they were then filed both electronically and in hard copies. I kept a running list of emerging themes and cross-referenced field notes with audio and videotapes.

Field notes consisted of comprehensive descriptions of the homes, the participants, and their activities. I also aimed for considerable reflexive content to my notes, in an attempt to at least recognise, if not eliminate, some biases. Reflections on my emotional reactions were treated as data (Kleinman and Copp 1993) and also helped me deal with the anxieties associated with fieldwork. Naturalistic interaction and my discussion with participants were documented as fully as possible; verbatim quotes and paraphrases were recorded with " " and ' ' notations respectively. The field notes also formed part of the analytical process (Lofland 1971), as interpretations and emerging patterns were also documented. My observations quickly became more focussed, as questions arising from the material, my main research questions and the literature were noted and used to guide further data collection. Increasing selectivity was employed in my field notes, as material became consistently repetitive. During Phase 2, my notes consisted primarily of contextual material to accompany my video recordings.

Interviewing staff

My aim with interviews was to examine staffs' beliefs regarding interaction with residents, and to get contextual information such as biographical details. My definition of an interview differs slightly from that of Cohen and Manion, who describe it as 'a two-person conversation initiated by the interviewer for the specific purpose of obtaining research relevant information' (Cohen and Manion 1989, p271). For my purposes, an 'interview' constituted any discussion with staff which covered topics relevant to my research, even if not initiated or directed by me. This highly informal approach enabled me to capitalise on opportunities for discussion,

often around issues which were highly relevant to the moment. It was rarely possible to make appointments with staff to interview them, because of the nature of their responsibilities. As a result, interviews with care staff could be characterised more as spontaneous conversations, often involving more than one staff member. I selected participants partly on the basis of how readily such discussion arose, but I did not exclude staff with whom it took longer to establish rapport. It is, however, unlikely that I fully eliminated bias resulting from the need to rely on accessible informants (Robson 1993).

A further reason for using this informal approach was the tendency for some participants to feel uncomfortable with anything they perceived as an interview. A quote from a tape-recorded discussion with a home manager (with whom I had made an appointment) reveals this:

> *I hate interviews by the way. So if I make any incorrect answers…! I suppose there is no correct answers.*

Despite the absence of structure and formality, there were clear roles of interviewer and respondent, and as in all communicative contexts, issues of power pertained. However, compared to structured interviewing, in principle this approach allows interviewees to participate more actively in setting the agenda, thereby "redress[ing] the imbalance of interests that invariably ensues from the circumstances and sources of interviewers [sic] agendas" (Sanger 1996, p63).

Although staff were aware that I might use anything they said (unless they asked me not to), the lack of clarity over whether what was taking place constituted an

interview brought difficulties over how to record what was said, since tape recording required additional consent. Maintaining rapport was of great importance and I certainly lost opportunities for tape recording, by not asking for permission when permission may well have been given. Transcription of audio recordings was more time consuming than typing up written notes, but yielded greater detail, whereas a benefit of notes was the immediacy with which I could skim the notes, to provide feedback or clarification to the participant.

I found that having both note taking and tape recording available to me at all times was valuable, but picking the method most appropriate to the context was challenging. The interviews were an important source of data, successfully revealing staff members' insights that would not otherwise have been available to me. However, frequently these insights were frustratingly limited, and practical constraints made it difficult to follow up a discussion with the same individual soon afterwards, to explore the issue further. It may be that engaging the commitment of specific staff more explicitly and helping them build up their skills and confidence in critically analyzing their own interaction may have helped.

In all I interviewed 45 staff including home managers, social care staff and nurses, both permanent and bank or agency staff. In addition, there were occasional discussions with visitors to the homes, such as family members, students and trainers.

Video recording

Video recording was an essential tool for capturing the naturally occurring verbal and non-verbal interactions between staff and residents, providing a rich record of data that permitted repeated viewing, and viewing by the participants within the interaction. As with any method, practical issues were a concern. I found that hand holding the camera or placing it on a chair or table next to me was preferable to using the tripod. This enabled greater selectivity of who I filmed (avoiding inadvertently filming people who had not consented), and when I filmed (avoiding lengthy periods when no interaction was going on); it was also possibly more respectful since it appeared less candid. Handholding the camera enabled close ups and panning out, thereby improving the quality of the footage and did not require the room to be arranged especially for the camera. I often included myself in the film, thereby treating my own interaction with residents as data alongside that of the staff.

The reduced anonymity afforded by video meant that this method raised significant sensitivities regarding consent to video the residents, and the ethical issues pertaining to this have already been discussed. The result of only having consent to video one or two residents in a home was that the video material I collected does not fully reflect the environmental context of interaction; using field notes to provide accompanying contextual information was therefore vital.

Observer effects might be expected to be more acute when video cameras are used in addition to observations. However, we monitor our behaviour all the time, and the extent of self-monitoring may simply be greater when being recorded (Malone

1997). For those who consented to being recorded, evidence from my observations of times when I wasn't recording suggested minimal impact and little tendency to stage interactions for the camera.

Both audio and videotapes were labelled, indexed, cross-referenced with my field notes (to link with contextual information and to enable triangulation with other data sources), and notes made outlining the contents. These notes were then formalised into Video Review Sheets (see Appendix 9 for an example), which were coded using the same codes as for my field notes. The codes applied to the video footage were entered into the database and episodes were selected for later detailed transcription, processes which are discussed in the next chapter.

Accessing the views of residents

It was my intention early on in the project to explore the perspectives of staff and residents on their own interaction, and in parallel, seek the views of a 'proxy' in the form of a successful AAC user. Interviewing staff has already been discussed. However, accessing residents' views was expected (and indeed proved) to be more problematic. The plan had been to use Talking Mats (Murphy 1998) to support informal interviews with the residents. This is a low-tech system using two-dimensional symbols placed on a mat, to facilitate discussion of quality of life (or other) issues. Talking Mats have been used with people whose communication is limited for various reasons, including learning disability.

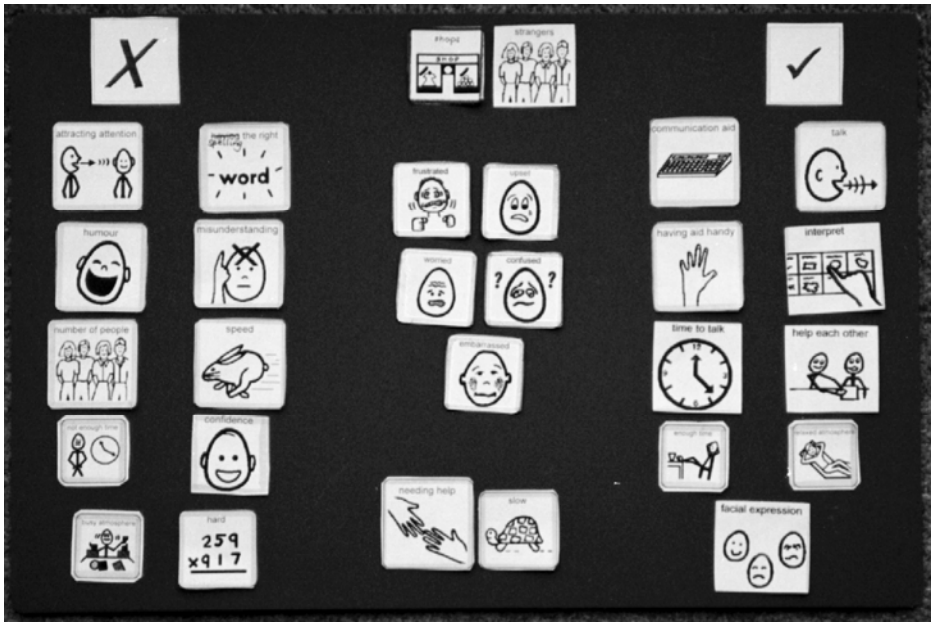

Figure 3:1. Example of a completed Talking Mat. This mat was compiled with a participant in a previous research project (Brewster 2004).

While I had anticipated difficulties in getting in-depth insights about communication, in the end these difficulties proved prohibitive. I had concerns about the necessity of myself or others choosing which symbols to offer during the process, and of this pre-selection constraining the views expressed (Brewster 2004). In the event, none of the residents were thought by carers to be familiar with or able to understand symbols and no such aids to making choices were in current use. The residents were generally unable to interact on topics of someone else's choosing, where these topics were outside the usual daily routine. A tape-recorded example from Sarah, the most communicatively able and verbal participant, may help to illustrate this point. Here I was trying to establish what she thought of the new arrangement of furniture in the kitchen, a topic that had been discussed already that day, to which Sarah returns:

1. Sarah: ( ) pen
2. Stephanie: Sylvia's pen
3. Sarah: cup of tea. No table.
4. Stephanie: no table?
5. Sarah: broke it.
6. Stephanie: I thought they just moved it.
7. Sarah: ( )
8. Stephanie: moved it to the other room.
9. Sarah: no table there. Broke it.
10. Stephanie: you like it better without the table?
11. Sarah: I got this chair. Me ankles hurt. And me shoes hurt me. Them
12. shoes.
13. Stephanie: so the table…
14. Sarah: there. [indicates her shoes]
15. Stephanie: yes there they are. Your shoes. So who broke the table Sarah?
16. Sarah: broke it.
17. Stephanie: do you know who broke it? It wasn't you was it? (2.0) Do
18. you like it now it's gone?
19. Sarah: yes. That chair is mine. [points to wicker chair in corner]
20. Stephanie: which is your favourite chair? [points to special one she is in]
21. Is that the comfiest? And that's yours, isn't it?
22. Sarah: ( ) teddy bear. [points to it on her wicker chair.]

What appears to be Sarah's opinion regarding the table occurs at line 19; unfortunately she did not expand upon her thoughts, and it is hard to be sure of the authenticity of this view.

Similar observations elsewhere guided my decision to abandon the idea of Talking Mats with any of the residents. I decided that to stand a chance of working, this method would require a huge investment of training and resources, and might still not yield significant insights. Furthermore, I concluded that the rather abstract nature of the topic, and the degree of self-awareness necessary to reflect on one's own communication, would not be possible with these individuals, whatever supportive methods were used.

These difficulties in reliably accessing the views of people with severe learning disabilities are likely to be common to other researchers, and to other methods of doing so. Indeed, accessing the views of people with severe learning disabilities in an authentic, credible and trustworthy way (Lewis 2002) remains an under-researched area. These challenges help to explain why so much sociological research which relies on interviewing to gather data from people with learning disabilities, excludes people with severe learning disabilities (Klotz 2004).

As noted above, a parallel strand of the investigation involved the participation of a proxy. Since this aspect of the project also proved to be less successful than hoped, and contributed only a little to the overall investigation, I provide here only a brief description; more detail of the proxy role in general, and of how I went about involving this individual in the project, is given in Appendix 10.

The involvement of a proxy can be, according to Bersani Jr, (1999) a solution to the problems discussed above, regarding the participation of people with severe communication impairments in research. Bersani Jr indicates that traditionally, (naturally speaking) family members, staff or advocates have been asked to act as proxy, but he suggests that those with similar disabilities would make more authentic proxies. I invited Alex to participate in my research, in this role. This young man has severe physical disabilities and cannot speak but is a very effective user of an electronic communication aid and does not have severe learning disabilities. He lives in a community home not unlike the research sites. He therefore fitted my requirement of having experience of being unable to speak while still being able to communicate potentially sophisticated views.

I met with Alex, exchanged email and phone calls on numerous occasions, particularly preceding and during data collection. While my intention was to retain control over the project, I nevertheless was open to Alex's perspectives and especially sought his views on the emerging findings regarding power relations within interaction between staff and residents. In practice I found it difficult to explain the rather abstract hypotheses I was exploring, and his insights remained limited; Appendix 10 discusses possible reasons for this.

The proxy role is also under researched, and could have formed a major component of this project, but I chose not to give it the emphasis it clearly needed in order for it to prove significantly fruitful. Similarly, I remain disappointed to have drawn the same conclusion regarding the goal of accessing residents' perspectives.

Participant involvement in the creation of data

Participatory research involves participants in the research process, and in this spirit, I wanted my participants to have some control over the data I gathered. This form of triangulation is similar to respondent validation (Hammersley and Atkinson 1983), which aims to establish that participants recognise the researchers' accounts of their beliefs or behaviours. However, triangulation is no guarantee of a consensus, or of ones' interpretations being correct. I was prepared for the possibility of contradictions as well as tallies, treating both as useful and illuminating. In theory, negotiating towards mutual understanding contributes to the

process of transformation, in both researcher and participants. It evens out the power relations between researcher and researched, by not exclusively privileging one person's interpretations over everyone else's. Further, giving participants some responsibility for ensuring the validity of the data means they are likely to be more receptive to the presentation of alternative perspectives. I attempted to involve my participants in the creation of data in two ways.

I gave written summaries of their interviews to four members of staff and had follow-up discussions with three of them. I was highly selective, only doing this when a particular interview had been fairly substantial and covered material that might be open to misunderstanding, and when the staff member seemed sufficiently confident to cope with this level of challenge. In practice it was virtually impossible to complete this process as swiftly as Sanger claims is necessary "for the data to resonate with the experience" (Sanger 1996, p70). I decided not to give participants full transcripts as the basis for further discussion, as this would take them an unreasonable amount of time to read. Also, "Verbatim accounts do not necessarily provide accurate representation of what occurs in interviews" (Sanger 1996, p71) because of the loss of non-verbal information. Summarizing the main points and presenting these in a readable form seemed to offer a sensible compromise.

The second method I used was to play video footage of interactions between participants back to them, immediately after filming, in a process of stimulated recall. Frequently staff would not be able to spare the time for even brief discussion, or did not want to watch the film at all. Other researchers have noted the discomfort frequently experienced by participants when they receive feedback from the

researcher (Aubrey et al. 2000, p163), and an anticipation of this may have contributed to their reluctance to watch and participate in debriefing. However, on several occasions I was successful in getting additional data in the form of discussion with the staff member, as we watched the film. As discussed above, it was not possible for me to access any residents' views about the films, due to their cognitive and communicative limitations.

I found that neither form of collaboration was entirely successful. The extent of engagement of participants with my research was limited, and therefore so were their insights and understandings. Discussion generally tended to lack depth. I was not convinced that discussion of the interview feedback constituted genuine verification of my perspectives, as participants' comments tended to be around wording or the confidentiality of the material, especially if the issue in question was an unfavourable one. One participant expressed discomfort at reading what I had written about what he had said (but did not wish to change it); handling such feedback appears to require a degree of confidence and maturity not all staff could be said to possess. Viewing video footage was usually an enjoyable novelty for residents but an embarrassing one for staff. Comments about the videos were never self-critical regarding their interaction. For both methods, the extent to which data were developed or transformed, or new data created, was limited. In hindsight, it appeared that my expectations of this level of engagement with the research process by participants were unrealistic, given the resources I was able to invest in participants as collaborators.

Feedback to participants

In order "to continue the collaborative spirit of the ethnographic approach" (Aubrey et al. 2000, p126) I planned to provide feedback about the research findings to participants, although I anticipated that this would present considerable challenges. My findings would be hard to grasp for someone without a background in the theories relevant to my study, and even basic concepts could be beyond the grasp of residents. Furthermore, some findings could be perceived by the staff as critical. When initially negotiating access, I was careful not to promise direct beneficial outcomes for participants, although my hope was that I might bring about changes in communicative practices.

My plan was to feedback directly to individuals, using whatever methods we agreed upon through negotiation; possibilities were discussion sessions and the creation of a poster for each home. This flexibility recognises the point made by Balandin (2003) that there is currently virtually no information about how best to share results of research, with participants with lifelong disability. My aim was to feed back my final findings (not provisional ones), rather than to arrive at a negotiated set of findings, as in true participatory research. In fact, I underestimated how hard it would be to provide any sort of feedback meaningfully for participants, and I discuss the reasons why in Chapter 7.

Conclusions

In this account of the methodological decisions regarding data collection, emphasis has been given to the ethical considerations and difficulties involved in research regarding people with severe learning disabilities. The next chapter discusses how data were coded and analysed, including the processes of transcription and the underlying theoretical perspectives, particularly Critical Discourse Analysis.

CHAPTER 4: ANALYSIS

Introduction

The previous chapter discussed how I collected data; in this chapter I describe how data analysis involved various processes, many of them occurring simultaneously. I describe the coding of data, use of a database, and transcription of interviews and natural interactions, before relating this to the theoretical frameworks I chose to use, and discussing some of the threats to the validity of this type of research. I conclude with profiles of the four residents who participated in the study.

Coding

An early phase in the process of analysis was the coding of the data. This was carried out along the lines advocated by Tesch (1990) who describes it as part of a process of de-contextualization and re-contextualization: the data are reviewed and segments are identified; segments are coded according to which category(ies) they belong to; the organizing system is gradually refined; segments are then re-contextualized, by gathering together all segments within each group. The data segments can then be read within the context of their topic. My coding of field notes and transcriptions (of both interviews and natural interactions) resulted in over 2000 coded segments (each roughly equivalent in size to a paragraph), and each segment received as many codes as were deemed appropriate.

The entire set of field notes were coded twice, during which process the codes evolved into a hierarchical structure (see Appendix 5, Figure 5: data codes mind-map). The first review of the data involved using an extensive and continually amended trial list of codes; I found that some codes could be eliminated (e.g. laughter), and others could be amalgamated (e.g. 'say please' was subsumed under 'politeness'). The second phase of coding used the final set of codes. Working definitions of the codes are given in Appendix 5. Some codes could sit in more than one category, and links between such codes are demonstrated in the mind-map. Below are brief descriptions of each category and the names of the codes within them.

Methodology: methodological issues.

- Gaining entry
- Field relationships
- First impressions
- Participant involvement
- Consent
- Feeding back

Care home practice: background information about activities within the residential homes.

- Domestic/practical
- Physical environment
- Management

- Roles
- Responsibilities
- Relationships
- Care needs

Power: instances of staff having power over residents and vice versa.

- Control
- Behaviour management

Discourses: The term 'discourse' is here used in the sense of Critical Discourse Analysis (CDA) (Fairclough, N, 1989) i.e. language as a social practice. Discourse refers to the taken for granted ways of doing and describing activity, from a particular perspective. The first four codes below (very) roughly correspond to Fairclough's levels of social organization: society as a whole, social institutions and social situations. 'Choice' refers to a commonly occurring discourse in service provision for people with disabilities, and 'conflict' refers to apparent conflict between such discourses e.g. choice of foods may conflict with a discourse regarding healthy living.

- Responses to difference
- Professional
- Individual staff
- House
- Choice
- Conflict

Interaction: This theme consists of two levels: general and specific styles of interaction.

General: The first level of interaction:

- AAC
- Non-verbal
- Amount of interaction
- Interpretations
- Excluded from conversation
- Denied sexuality

Styles of interaction: the second level on the theme of interaction. Codes refer to instances of different styles of interaction, and also references made to them. The word 'style' has been chosen, as a neutral term, not relating to any theory; it encompasses pragmatic and discursive purposes of utterances or behaviours.

- Fun/banter
- Discipline
- 'As if'
- Information exchange
- Directives
- Requesting
- Attention
- Politeness
- Scaffolding
- 'Tell Steph'

- Pedagogic
- Test questions
- Correcting
- Word repetition
- Topic maintenance

Using the database

The large volume of data was the main influence in the decision to use software to assist in its management. I was unfamiliar with any appropriate software so explored various options. For example, I trialed a demonstration version of Nvivo, a data analysis software package for qualitative research. The opinions of experienced researchers were also considered. I was aware of the risk of being tempted to do the analysis in a certain way because the software favours that way: i.e. the computer unduly directs the analysis process, a risk pointed out by Tesch (1990). In the end, I decided to design my own database in Microsoft Access rather than to use specialist software to support my analysis of coded data.

I used the database in a number of ways. My initial approach was unstructured: I explored possible lines of enquiry relating to my research questions. For example, I examined the frequency totals of each code (see Appendix 6) and their locations; I found that certain codes (e.g. 'correcting') occurred predominantly in association with one resident which suggested that this might be a distinctive feature of the

interaction occurring there. I was also able to examine the extent to which my grouping of codes into categories was reflected in these codes occurring in the same locations in the data, or indeed whether there were other links that had not already occurred to me.

Another strategy was to pick a high frequency code (e.g. 'amount of interaction') and view its distribution alongside all other codes; this gave me, at a glance, an impression of which codes most commonly coincided with which. This technique enabled me to spot clusters as well, since coded paragraphs were entered by location, in date order. It was important to remember that to a certain extent, a particular code would simply coincide with other frequently used codes by chance.

Later the database was invaluable in identifying pieces of data which had received a certain code. Such ideas arose both from perusal of the data in general, from using the database, and from consideration of aspects of theory. In other words, I worked in the way described by Richards and Richards (2003) for qualitative data analysis, which involves working up from the data and working down from theory. Use of the computer as a 'code and retrieve' method supported the emergence of themes relevant to my research questions. For instance, when I wished to explore the data relating to the theme of 'politeness' I ran a database 'query' which listed all those paragraphs, indicated to which residential home they pertained and the nature of that data (observation notes, interview transcript, video footage or documentation). By this means I was able to 'recontextualise' (Tesch 1990) data by placing data from different occasions alongside each other. I was also able to triangulate between

different types of data: a specific episode of video footage would also have entries in my field notes.

My database had a number of advantages for me. Firstly having designed it myself, it gave me full control over how I went about its use. Limiting its application to locating pieces of data meant that I was not drawn into feeling that the database could provide any interpretation of its own accord: the database did not carry out any analysis, it merely followed my instructions However, many ideas were generated by using the database, most of which I did not pursue because of the need to retain a focus on the purpose of the research. Like Silverman (2000), I found that carrying out very detailed readings of extracts of interaction which I did later was not helped by the computer (except in the sense of the organization, retrieval and presentation of content). I am not able to speculate whether the use of Access rather than software specifically designed for qualitative research was the optimum choice, but feel reasonably confident that the decision did not influence the final conclusions of the research.

Handling video data and selecting samples for transcription

The process of transcribing video footage was very time consuming (frequently taking me well over an hour to transcribe less than a minute of interaction) so careful selection was necessary. I started by logging the six and a half hours of footage I had, from the four different homes. The episodes of footage are summarised in Appendix 8. For each episode of recording I created a Video Review

Sheet (see Appendix 9 for a sample video review sheet), which recorded identification details, and brief descriptions of the activity and participants. I added codes and inputted them into my database, which meant that the video data were treated in a similar way to interview transcriptions and field notes. The process of writing video review sheets constituted a "survey of the corpus" of video data (Fairclough 1992b) from which stretches were identified as having particular salience to my research, or in Fairclough's terms, that "yield as much insight as possible into the contribution of discourse to the social practice under scrutiny" (p230). I also had to ensure that these stretches contained interaction which was of adequate visual and audible quality to be transcribed.

In fact this proved much too wide a net to cast, for all such sections to be transcribed. The next round of selection therefore attempted to achieve a sample of transcribed data that was broadly representative of all of my data, in terms of participants and activities or settings. Each initial transcription was accompanied by an unstructured commentary consisting of observations generated both by transcribing and viewing the tape and contextual information from corresponding field notes. I concluded this process when I felt I was no longer encountering new or fresh material. This transcribed sample cannot be said to be representative of the interaction which occurred: this was not my aim. This set of transcriptions was analysed using concepts derived from Norman Fairclough's Critical Discourse Analysis (CDA) (see below), and these applications of theory enabled me to ensure that this analytical framework was indeed valuable and applicable, before continuing further. The second round of transcriptions occurred during the next phase of analysis as themes began to emerge; this is discussed below.

Transcription

"The transcript is the researcher's data", (Soto and Grove 2000) and my transcriptions of staff interviews and interactions with residents (which were dealt with in different ways), combined with contextual information from my field notes, constituted my data set. Transcription is never a theory-neutral process (Muller and Soto 2000a); no transcription provides a complete record of interaction so what is included and excluded result in the transcript being "a construction rather than a neutral record of talk" (Taylor 2001, p34). I was faced with a difficulty here, since an ethnographic approach to analysis is primarily driven by the data, but I needed to decide what aspects to transcribe in order to construct my data for further investigation. Therefore the process of transcription and data analysis was iterative: analysis of initial selected transcriptions contributed to the preliminary development of themes; further selection of excerpts for detailed transcription was then aimed at shedding more light on these themes. So selectivity of transcription was influenced by the theoretical frameworks I chose and by existing research about similar interactions.

Interviews with staff and some of the interactions involving Sarah and Claude (who could speak) were transcribed in full usually from audiotape. Widely used orthographic transcription conventions were used (see Appendix 4). These transcriptions were coded alongside the rest of my field notes. The selection of excerpts of videotaped interactions with residents for transcription was described above, and the subsequent stages are explained below.

Identifying the beginning and end points of each transcription varied with each excerpt. As with deciding when to turn the video camera on and off in the field, choosing when to start and stop transcribing inevitably involved a degree of arbitrariness. Some excerpts had natural boundaries e.g. a person entered the room, interaction occurred then they left. More often I had to decide which manageable sized stretch (usually little more than a minute) best captured the features of the entire interaction or the features I specifically wished to illustrate. In all, I videoed about six and a half hours of interaction, of which I transcribed approximately 30 minutes. Transcription of audio taped interviews and interactions was additional to this.

Considerable attention was paid to my choices of transcription conventions and layout; my decisions were influenced by the purpose of my analysis, which was to examine the dynamics of multi-modal interaction. The issue of how different transcription layouts can have implications for the analysis of atypical interaction is discussed in the next chapter with reference to Sarah's style of topic control.

For predominantly non-speaking individuals where interaction is multi-modal, transcription is not straight forward, and indeed, there is as yet no consensus about theoretical and methodological approaches to multi-modal transcription (Soto and Grove 2000). Most spontaneous language samples in the literature consist only of spoken language, with gestures being viewed as paralinguistic and having only a supportive role in the communication of meaning. In multi-modal interaction, it is important to separate the dimensions of modality and of meaning (Hughes 2000) since the meaning may be conveyed by different modes of communication. Muller

and Soto (2000) describe a number of transcription styles which go some way towards acknowledging this complex integration of verbal and nonverbal behaviours that occurs in interactions involving non-speakers. Non-verbal modalities such as gesture and eye-gaze are frequently idiosyncratic, and are highly dependent upon immediate context for their meaning. A good knowledge of the context and the individual are required for intended meaning to be interpreted correctly, and indeed, I drew heavily on my experience of spending time with these individuals in the field, supported by perusal of field notes in interpreting the interactions.

Yet it is not simply a problem of how best to convey meaning to the reader. As Ochs (1979) points out, inadvertent researcher bias, in the form of privileging spoken utterances over non-verbal communication, and giving prominence to the speaking partner should be avoided in a transcript. For transcribing interaction with very young children she proposes individual participant columns, in which the child's contributions are placed to the left (and so they are read first on the page) of the adult's. This has implications for the perceived power relationships of participants; since it does not coincide with our cultural biases, a move is made towards equalising the relationship between adult and child.

After trying several different layouts, I settled on one in which each participant was allocated two columns: one for non-verbal and one for verbal behaviours (i.e. modality). In order to offset some of the bias referred to above, the residents' interaction was placed to the left of the page and non-verbal behaviours to the left of verbal or vocal information. I found that a few behaviours occurred so frequently

that the transcription became less cluttered if those behaviours were represented symbolically. These were the direction of eye gaze and pointing, represented as → or ← and ► respectively. Also, when vocalisation was too indistinct to be transcribed, the number of syllables was noted between brackets. Everything else was described in text. Instead of line numbers to facilitate referring the reader to specific utterances, I felt that presenting one line of transcription per second (using the tape counter on the video player) was more meaningful. As well as enabling the reader to get a sense of pace of the interaction, it presents information about relative times that each participant holds the floor- an aspect which could be relevant to the analysis of power relations. The example in Figure 4:1 demonstrates these various features.

Venue: Number 32
Date: 27.04.04
Setting: kitchen, following cookery session
Participants: resident Sarah; staff Sue; researcher behind camera.
Duration: 33 seconds
Selection criteria: coded as 'requesting'

Key:
→ looks towards…
← looks away
►points towards
(n) unintelligible speech, (number of syllables)

Time (Secs)	Resident: non-verbal	Resident: verbal/vocal	Staff : non-verbal	Staff : verbal
1.	→ Sue	I'm wet	Back to camera, wiping crumbs off S's tray and footstool	
2.				You're wet?
3.		mm		
4.				You sure you're wet

Figure 4:1 An example of the final layout of multimodal transcription.

Theory underpinning analysis

A number of theoretical approaches to analysis were considered. Conversation analysis was one of them, because it deals with naturalistic data in the form of interaction. It uses detailed transcriptions on which structural analysis is carried out; i.e. it is data led rather than theory driven. The reason I did not choose conversation analysis is that it lacks the critical component I wished to incorporate into my analysis. I also explored the field of social justice, both generally, and in relation to people with disabilities; obviously this explicitly political approach incorporated a critical stance (towards content) but I was unable to find within it the tools needed for detailed analysis of interaction (the process). Another approach I considered, because of its incorporation of visual (not just linguistic) communication was that of multimodal discourse (Kress and Van Leeuwen 2001); the approach is applied predominantly to mass media, rather than to interaction in the private domain so again it did not provide the tools I needed. Critical Discourse Analysis (CDA), particularly the approach of Norman Fairclough, was found to provide both the techniques of analysis and the critical interpretations I was interested in.

Preliminary applications of CDA to transcriptions of resident interactions enabled me to identify which aspects of this analytical approach were likely to be most relevant and enlightening, given my research questions. Much of the discourse between residents and staff is fragmented, brief, and consists of non-linguistic behaviours; all is spontaneous. Therefore many areas of Fairclough's framework of CDA seemed irrelevant or impossible to apply to data of this nature. Below I describe which aspects of CDA were found to be most applicable to my samples of

discourse. They relate to the 'micro' level of analysis of texts. However, Fairclough (1992b) warns against text analysis being carried out in isolation from the other two dimensions, discourse practices and social practice. Analysis of discourse practice involves examining the processes of production, distribution and consumption of texts. Analysis of social practice attempts to specify "the nature of the social practice of which the discourse practice is a part, which is the basis for explaining why the discourse practice is as it is" (Fairclough 1992b, p237). An ethnographic approach to data collection meant that I was able to make links with these progressively more 'macro' dimensions of analysis.

I identified which codes were relevant to the examination of power relations, then narrowed this down further by comparing the codes to the concepts from CDA which seemed most relevant to interactional data. An overarching concept relating to interaction is that of type of exchange (Fairclough 2003) of which there are two main types: activity exchange and knowledge exchange. In an activity exchange the focus is on doing things and getting others to do things; in a knowledge exchange the focus is on eliciting and giving information, making claims, and stating facts. Both types can be initiated by the knower or doer, or by the person who wants to the knowledge or wants the other person to act. My codes 'test questions', 'requesting' and 'directives' (discussed in Chapter 5 (Part 2)) were pertinent to issues of type of exchange; these codes referred to the way information is exchanged and knowledge tested and evaluated, and how residents and staff elicited action from each other.

Another area of CDA I explored was interactional control (Fairclough 1992b). This is about who controls the interaction, whether this control is negotiated, or exercised

by one partner more than another. My codes 'topic maintenance' and 'excluded from conversation' related well to the concept of interactional control. These codes identified data that would support an exploration of how topics are introduced, picked up and developed and by whom, and how control is exerted over who participates in interaction. Another interactional control feature is turn taking, which was not explicitly coded but which pertained to all examples of interaction data; this was also examined in detail. These themes are explored in Chapter 5 (Part 1).

In addition, the codes 'politeness' and 'AAC' were selected for analysis. What conventions of politeness apply to the discourses of a social practice is highly indicative of the social and power relations that pertain (covered by Chapter 5 (Part 2)). Also, because of the particular concern of this project with AAC, I examined this in detail (see Chapter 6) in the same way as the other themes, although it is obviously not addressed by the discourse analysis literature.

The codes identified above were used to run "queries" on the database. For example, I used the database to identify all examples of video and audio taped footage which I had coded as 'politeness'; the result of this query constitutes Appendix 7. This then enabled me to select excerpts to analyse further (and transcribe, if I had not already done so), with particular attention to Fairclough's category of 'politeness'.

At a higher level of analysis, the concept of 'speech function' was helpful; this describes the things people do in interaction. Fairclough (2003) describes the main types as statement (statement of fact, prediction, hypothetical, evaluation), question,

demand (including requests), and offer (including promises, thanking and so on). In addition, an interaction will often have a predominant grammatical mood (Fairclough 2003), whether declarative, interrogative or imperative. What was of interest to me were "metaphorical relations" (Fairclough 2003) between these various aspects of an interaction. For example, one speech act may appear to be another, as when a statement of fact is implicitly evaluative, through selecting certain facts and not others; or a demand may be made in a grammatically interrogative form rather than the imperative. Also an "apparent orientation to knowledge exchange" may disguise a "deeper orientation to activity exchange" (Fairclough 2003, p112) so as to be more successful at achieving action than an overt demand would be. Table 4:1 illustrates horizontally the main associations that are typically found between types of exchange, speech functions and grammatical mood, as discussed by Fairclough (2003).

Type of exchange	**Speech function**		**Grammatical mood**
Activity exchange	Demand		Imperative
	Offer		
Knowledge exchange	Statement	Statements of fact	Declarative
		Predictions	
		Hypotheticals	
		Evaluations	
	Question		Interrogative

Table 4:1 The main associations found within levels of analysis: type of exchange, speech function and grammatical mood (after Fairclough 2003).

Clearly there is only partial correspondence between my codes and Fairclough's categories, and this was to be expected. The codes arose predominantly from the

data themselves; CDA was not decided upon as an analytical tool until after data collection and coding were complete. Nevertheless the degree of correspondence that there is, is sufficient to justify the application of this analytical approach. The need to keep a tight focus on my research questions and to keep the project a manageable size meant that not all codes or aspects of analysis that were of interest could be explored, so the analysis is necessarily incomplete. In any case, there is no single definitive objective analysis of a text, merely alternatives. Analysis is selective, based on what questions are being asked of the text, and the motivations of the researcher. In a critical analysis, these are explicitly concerned with issues of social justice. The issue of bias in CDA is considered further in the final chapter, and in the next section validity is discussed more broadly, as it pertains to qualitative research in general.

Validity

Qualitative research is particularly prone to bias because of its reliance on the individual researcher. However, because this type of research does not rest on the assumption of objectivity and neutrality, Lincoln and Guba (1985), amongst others, have suggested alternative ways of conceptualising the traditional criteria of validity, generalizability, and reliability for assessing the quality of case studies and qualitative research.

Credibility – "that the enquiry was carried out in a way which ensures that the subject of the enquiry was accurately identified and described" (Robson 1993, p403) – can be achieved by prolonged involvement, persistent observation, triangulation and peer debriefing. Peer debriefing was not available to me (although supervision was), but the other techniques were used in my research. I achieved triangulation by using several methods, and by including "accounts of participants with different roles…combined with the researcher's own" (Aubrey et al. 2000, p57). Credibility subsumes the concept of dependability (parallel to reliability), which requires that the research process is systematic and fully documented.

Transferability (analogous to generalizability) constitutes the extent to which the findings are relevant to other settings. I have sufficient data to provide thick descriptions, the findings from which are likely to demonstrate significant comparability (Nunan 1992). The use of multiple case studies provides grounds to claim wider relevance (Hammersley 1992) to similar settings and interaction situations.

Confirmability demands the provision of enough information to judge "whether the findings flow from the data" (Robson 1993, p406). This is a particular threat to the trustworthiness of ethnography, because only a sample of data can be presented for independent analysis (Nunan 1992). Further, as Nunan (1992) points out, the subjectivity of the researcher (in my case, as someone differing in physical and intellectual ability from the residents, and in social and educational status, and race from many of the staff) must be acknowledged. A high degree of reflexivity is required at every stage of the research (Taylor 2001), including the process of

writing ethnography (Humphreys 1999), and aspects of this are documented in this thesis.

Nevertheless, I am confident that this research will offer a valuable and original analysis of how the power relations between people with learning disabilities and staff are manifested in interaction, how this may be linked with AAC non-use.

Conclusions

In this chapter I have described how data were managed and analysed; the processes involved in transcription formed a significant part of this phase of the research. The next two chapters present the findings related to various themes. In Part 1, interactional control features (Fairclough 1992b), which ensure smooth running of the interaction, are discussed; also in the next chapter, Part 2 covers the activity exchange, a type of interaction in which participants are trying to get one another to do things; findings pertaining to the theme of politeness are also discussed. Part 3 of the research's findings, Chapter 6, is devoted to the theme of AAC. But first I briefly introduce the four residents, who participated in the study.

RESIDENT PROFILES: Mary, Claude, Sarah and Hilary.

The following information is based on my observations, documentation held by the homes, discussions with staff and, in the case of Sarah and Hilary, their mothers.

Mary

Mary lived in Bungalow A, and moved next door (as a result of a reorganisation of services) to Bungalow B in between Phases 1 and 2 of my field work. She is aged about 70. She is friendly and affectionate, and appears contented most of the time. She is interested in nice clothes and enjoys shopping. She is able to walk short distances, and is more independent than the other residents in Bungalow A (but not B). Mary always looks pleased to see visitors, and loves attention. She likes looking at pictures, and often has women's magazines and holiday brochures to hand, which she will flick through on her own or with anyone who shows an interest. Staff in the home often treat Mary fondly; however, they also describe and treat Mary as a 'naughty girl'. More than one member of staff told me that they treat Mary 'like a child' because of her uncooperativeness.

According to her file, Mary has 'severe learning disabilities'. She likes 'making jewellery' and 'reading' (I often observed her threading beads and looking at magazines, although I have seen no evidence of her understanding written text). The file states that she likes company and being in a group; she dislikes being told what to do. A brief Speech and Language Therapy report says that Mary "responds to simple everyday spoken language" but finds it harder to respond to sentences of more than 2-3 ICWs (information carrying words). This report states that expression

is mostly non-verbal: she takes people to what she wants, uses facial expression and body language, and makes "word-like sounds". Although not able to point accurately to things she wants, the SLT reported that "with familiar people she is able to adequately express her immediate needs and wants and dislikes".

My impression was that Mary initiates so much communication that it can feel demanding for staff. She often uses a picture, person or object within view, as an object of shared attention. She typically vocalises in an undifferentiated way, until she has your attention; then she points (e.g. to the fish tank), then looks back to you to check you have seen it. The person usually responds by naming or commenting on what she has pointed to. When she points, Mary may name the picture, person or object, but only does so when she has a recognisable verbal approximation in her repertoire; her recognisable spoken words include: tea, fish, baby and mama and these are used appropriately to refer to broad categories of items. Mary has a communication book, consisting of several pages of pictures and symbols, representing people, places and activities of relevance to her; she enjoys browsing through this book but it appears never to be used to communicate a goal- a conclusion that is backed up by staff who have said 'she never uses it'.

Claude

Claude also lives in Bungalow A and has known Mary for many years; he is about 50. He has a friendly manner and engaging smile and enjoys talking; he is both well known and well liked amongst the community of residents and staff on site. Claude is highly physically dependent, but usually attempts to feed himself at mealtimes. According to his file, Claude has no family contact. He has cerebral palsy, spastic

quadriplegia, and epilepsy. It is documented that he likes "going out for meals, and "helping" in the kitchen". The file's use of " " may be to do with the extreme physical limitations experienced by Claude, rendering him unable to carry out such tasks; he nevertheless frequently offers help and staff try to help him feel as if he is contributing.

Claude can communicate verbally, although first impressions may lead the listener to assume greater language skills than he possesses. Claude has a repertoire of stereotypical phrases which he uses appropriately some of the time. For example, the file reports: "If unsure he tends to respond 'it's alright'. If unwilling to participate he tends to respond 'in a minute'." As I got to know Claude better, I recognised other stereotypical phrases such as 'round the corner, it's not far', often in reply to questions involving 'where?'.

While his friend Mary is described by staff as 'lazy' and 'naughty', Claude is described in opposition to this, as 'good'. He is polite, saying 'please' and 'thank you'. Claude will often enquire 'how are you keeping? All right?' (stereotypical phrases from his repertoire). Staff have described him as aspiring to a role of honorary staff member. Mary is often on the receiving end of this, when Claude tells her off and joins staff in remarking on her bad behaviour.

Sarah

Sarah lives at Number 32; she is the most able and verbal of the residents here. She lived in a large hospital for people with learning disabilities, from age 11 until 1994

when she moved to a staffed community home; she is now in her 50s. She moved to Number 32 when it opened a few years ago. She has a lot of contact with her family, and her elderly mother is a frequent visitor. Sarah has a very strong presence in the house, because of the amount and volume of her speech. She takes an interest in the running of the home, although her participation is limited by her physical disabilities (she is able to walk indoors only with the assistance of two people). She spends most of her time colouring with her crayons in the dining kitchen, where much of the staff activity occurs, and likes to be in conversation with them.

Sarah also occupies herself with the box of things by her side; it contains an assortment of her belongings such as colouring books, crayons, a teddy bear, and her purse. These items frequently provide the topic of conversation; indeed, a characteristic of Sarah's style of conversation is that she returns to a topic repeatedly throughout the day, rarely adding any new information to the exchange. This can become wearing for her regular communication partners, who are not always able to engage Sarah in other topics.

Sarah's file focuses mainly on medical and behavioural issues; the emphasis on the former is unsurprising given that it reports deterioration in health and physical abilities in recent years. What was more surprising to me is Sarah's behaviour being a recurring theme, since she appeared to me to be happy and calm, although perhaps demanding, the majority of the time. This has clearly not always been the case. For example, in a relatively recent letter from her doctor it mentions temper tantrums during which she can "become extremely overwrought, noisy and aggressive." Although she still clearly wants plenty of attention and can be impatient, I never

witnessed a tantrum; this may not be a coincidence, since Sarah was responsive to the extra attention afforded by my visits.

The file also contains information about her communication skills, which were largely borne out by my own observations; the file indicated that Sarah 'has greater understanding if situation/person is familiar', 'is not able to understand more complex sentences', and 'is able to make wants/needs known'. She is reported to only have a limited understanding of information to enable choices and decisions to be made for herself. She can recognise her name but no other written words.

Hilary

Hilary lives next door to Sarah at Number 34. She moved here in 2000, having lived in a large residential hospital since age 16, when according to her mother she became unmanageable at home. She is now in her late 40s and continues to have frequent contact with her mother and sister. Hilary has a big impact on the atmosphere of the house since she is very vocal and mobile. She is able to walk but may use a wheelchair when outside; she enjoys trips out in the home's minibus or on public transport. She has a playful side to her nature, enjoying games, and various toys which her mother gives her. Hilary has a long standing love-hate relationship with another resident, Trish, with whom she lived in the hospital previously. Together they share an obsession with paper. Hilary possessively hides any paper she can lay her hands on and any important documentation in the home has to be kept locked away.

In common with Sarah, behaviour management has been a long standing concern for those caring for Hilary. She has been assessed as requiring 1:1 supervision at all times since she can show aggression mostly in the form of hitting, grabbing or scratching. Such behaviours are thought of as ways of communicating; for example, Hilary's file explains that she portrays anger, jealousy or frustration by "being violent to others or furiously rubbing her own head." Laughter, crying, and screaming are also used to express herself. In addition, Hilary uses a small number of spoken words, understandable to familiar listeners, referring to people, places and activities. Her range of gestures is very narrow; for example, she points to her mouth to request drink, food or attention. Hilary uses and understands a few Makaton signs, but no-one else she comes in contact with nowadays (including her mother) uses Makaton. There is a consensus amongst those who know her that there is a wide discrepancy between her expressive and receptive abilities, which may account for the challenging behaviour she demonstrates. Hilary's key worker believes she thrives on attention, and the stimulation of going out into different environments, both of which result in improvements to her behaviour.

CHAPTER 5:

FINDINGS (PARTS 1 AND 2)

Introduction

In the previous chapter I described how I collected and organised the large quantities of data and how I went about selecting and analysing the samples of transcribed interaction. The sample selection was related to theories of Critical Discourse Analysis (CDA). This chapter explores the themes that arose from my data and to which CDA seemed particularly relevant. As is usual in qualitative research, constraints of space have meant that only a few selected examples are presented, for illustrative purposes.

In the first part of this chapter I examine the interactional control features (Fairclough 1992b) that ensure the smooth running of interaction. This is about who controls the interaction, whether this control is negotiated, or exercised asymmetrically. In particular I look at turn taking and topic control. Related to this is the phenomenon which I coded as 'excluded from conversation', interaction in which residents are not permitted or are not able to participate; this exclusion is a frequent result of aspects of turn taking and topic control.

In the second part of the chapter, I examine aspects of interaction related to one of the two types of exchange identified by Fairclough (2003), the activity exchange, in which the focus is on doing things and getting others to do things. The use of

politeness conventions frequently co-occurs with such requests, and this is treated in a section of its own. This is highly relevant to the concern of this project, since what conventions of politeness apply to the discourses of a social practice are indicative of the social and power relations that pertain. I go on to describe a particular type of exchange structure, involving the test question, which illustrates many issues to do with topic control and turn taking. Throughout the chapter, reference is made to the possible implications for AAC, and this theme of AAC is discussed more fully in the next chapter: Findings (Part 3).

Findings: Part 1

Turn taking

Turn taking plays a significant role in the enactment of power relations in interaction. In this discussion I present examples of resident-staff interaction in which turn taking works smoothly and ones in which it does not. I also examine instances in which apparent failures may be due to limitations of conversational competence, and ones where power appears to be being contested. I conclude with a discussion of the implications of this for potential AAC use.

Conversation Analysts view turn taking as a phenomenon collaboratively achieved by participants, but as Fairclough (1992b) points out, the rights and obligations of turn taking may not be equally distributed. Related to turn taking is the issue of

spontaneity and initiation in interaction. According to Carter (2002) low levels of spontaneity in the communication of people with severe disabilities (and the possibility of AAC use exacerbating this) is a widely reported phenomenon. However, Carter's review also identifies research which found that levels of initiation were in proportion to overall levels of communication amongst AAC users with learning disabilities. In other words, these individuals exhibited low levels of communication generally and equally low levels of initiation.

The notion of "speakership" (Ng and Bradac 1993), is helpful (although is not interpreted by the authors as encompassing non-verbal communication); it includes features of both turn taking and initiation. Speakership provides the power to control the immediate interaction and create an impression subsequent to having gained a speaking turn. Someone unable or unwilling to achieve speakership lacks these immediate opportunities, and long term may be regarded as lacking influence. Speakership is allocated either by the current speaker who selects the next speaker, or the listener may self select. Devices for allocation include naming the addressee, adjacency pairs ("two utterances that are produced by different speakers and are tied together in close sequence such that the first part (e.g. question) always precedes the second part (e.g. answer)" (Ng and Bradac 1993, p72), intonational contours, kinesic movements, tag questions and social identities.

Before presenting the first transcription, here is a reminder of the transcription conventions used in presenting multimodal transcription of video footage. These, and those pertaining to transcription of speech from audio recordings (see Appendix

4), and are discussed in Chapter 4: Analysis. Unfortunately, some variations (e.g. in line spacing) were necessary to enable consistent use of portrait format.

→ looks towards

← looks away

►points towards

merged cells = continuing behaviour

(n) = unintelligible speech (number of syllables)

The first piece of data I present (Excerpt 1) illustrates Mary playing a lead role in the collaborative management of turn taking. Mary attains speakership (by self-selecting) at second 12 by pointing to the hi-fi. What follows is a series of sequences in which Mary indicates something round the room, I respond verbally, then allocate the next turn to Mary who takes it, by pointing again. Mary initiates these sequences at 12, 22 and 34. Elaborations also occur, involving unintelligible vocalisation from Mary, and additional comments or questions from me. Mary seems to be bestowing or withholding speakership primarily through the direction of her eye-gaze which alternates between me and things and people around the room. By controlling the interaction, Mary is able to ensure that she can maintain her participation in it.

Excerpt 1.
Setting: living room, sat on adjacent easy chairs; music playing; the fish tank had recently been cleaned.
Participants: Mary (resident) and Stephanie (researcher, S). Other staff and residents (Sally) all off screen.

Time secs	Resident: non-verbal	Resident: vocal	Researcher: non-verbal	Researcher: verbal
3	→ S; → and ► camera		→ M	
4				
5				
6				
7	←			You were telling me about holidays
8				
9				
10				
11				
12	→and ► hi-fi; holds hand		Holds M's hand	
13	→ S		→ hi-fi then M	Are you pointing to the music?
14		(1)		
15			→ M	You like this tune?
16	→around room			
17				
18				
19				
20				
21				
22	→ fish tank		→ and nods to tank	What about the fish?
23				
24				
25	→ and ► fish tank	(2)		
26	→ S			
27	→ S			they look a bit murky still, don't they?
28				
29		(2)		
30				
31				The water will go clear in a minute
32	→ around room			
34	→ and ► Sally		→ Sally.	
35				
36				
37	→ S	(3)	→ M; → Sally	Sally? (1) yeah

The next example (Excerpt 2) demonstrates a sharp contrast with the orderly sharing of turns described above. I was not able to discern coherent turn taking involving Hilary and Sylvia. Hilary appeared agitated during this exchange, vocalising loudly and profusely. The problem seems to be about Hilary requesting a drink which Sylvia offers to give her, on condition that Hilary goes to the kitchen to get it. What may be happening here is behavioural non-compliance with a staff member's

directive. Hilary is not opting out of conversational turns offered to her, rather there is a considerable degree of overlap but it is not clear who is interrupting who. Any failure in turn taking would not appear to be because of incompetence in Hilary's turn taking skills.

Excerpt 2
Setting: lounge
Participants: resident Hilary sat on sofa holding magazine and staff Sylvia (S). Researcher behind camera.

Time, Secs	Resident H: non-verbal	Resident H: vocal	Staff S: non-verbal	Staff S: verbal	Res'cher
5.	► mouth, rapidly and repeatedly; →researcher	(1)	Stood in front of H		
6.					
7.					
8.			Gestures towards self	You're not going to stay with me?	
9.	→ S	(3) raised pitch			
10	Waves magazine at S	(Many syllables)			
11			Gestures towards self	I'm here	
12			► floor at her feet		
13			Walks to door; →H	No I'm not going I'm staying here. I'm staying here	
14			Walks back towards H		
15			Stands by door facing H	I'm in the kitchen	
16				Do you want a drink?	
17		(1) emphatic			
18					
19				You'll have to come through.	
20	Waves R arm	(Many syllables)	Walks away	Come through Hilary	
21	→ magazine		Walks into room towards May, off screen	I'm not bringing it in here.	
22			Off screen		
23	→away			I'm not bringing it in here.	
24					

25				May, do you want a drink?	
26					
27	→ S				
28					
29					
30				Steph do you want a drink	
31	► mouth, repeatedly	(1)	Walks towards H		I wouldn't mind
32	→ magazine		► and → H	Do you want a drink?	
33	→away		Walks along corridor	Come and get it then	
34		(1)	Gestures to 'come'		
35			offscreen	I'm not bringing it in there	

There are other instances, however, which suggest that Hilary may lack the ability to promptly take turns allocated to her, for example in Excerpt 3 when Michelle asks Hilary to *Say thank you; thank you; do it then, thank you [does Makaton sign 'thank you']* between seconds 2 and 5; Hilary then produces an approximation to the sign at 7. The faster pace of this interaction raises the strong possibility that Michelle did not give Hilary the time she needed to respond after the first request, or it may be that Hilary was only able to produce the sign on imitation. One characteristic of interaction in this dyad generally is the frequency with which Michelle uses Hilary's name during interaction e.g. *What did I say later? Hilary. Hilary.* This suggests that Michelle anticipates difficulties in Hilary's uptake of allocated turns, even when she uses the very obvious device of naming her as addressee, one of the methods of doing so identified by Ng and Bradac (1993). This was confirmed by Michelle, who told me she was often conscious of the need to attract and retain Hilary's attention when talking to her.

Excerpt 3
Setting: lounge; researcher is hand holding camera
Participants: resident Hilary sat down; staff member Michelle stood in front to the side.

Time: secs	Resident: non-verbal	Resident: verbal/ vocal	Staff: non-verbal	Staff: verbal
1.	Drinks from cup		Watches H drink	Hilary.
2.	Lowers cup; → M	vocalises		Say 'thank you'
3.				Do it then, thank you
4.			Makaton sign 'thank you': hand to chin	
5.				
6.				
7.	Hand moves towards and away from face		Looks at researcher	
8.				Yeah, well done

The next example also illustrates a resident not taking turns allocated to her, but probably for different reasons. In Excerpt 4, Mary's not taking turns when identified as next 'speaker' appears to be an act of resistance rather than a result of her limited skills. A staff member, H repeatedly asks Mary to identify a green bead from her box: between seconds 22 and 53 he says 'green' thirteen times. Mary does not respond until 22 seconds after the first direction to 'get the green one', at which point she picks up a white bead and shows H while laughing and smiling. Mary may not know colour names but it is notable that she made no move to take the turn allocated to her. The interpretation which may be most convincing is that she did not wish to participate in this conversation or task. Mary has control over this interaction by withholding any attempt at compliance, without needing to resort to the ultimate sanction of walking away- an option not available to residents with more severe physical disabilities such as Claude.

Excerpt 4
Setting: Mary sitting on sofa with box of beads on her lap. H approaches Mary.
Participants: staff member H and resident Mary

Time: secs	Resident: non-verbal	Res't: verbal/ vocal	Staff: non-verbal	Staff: verbal
1	→ H		Moves towards M, sits on sofa arm	so
2	→ box of beads on lap		→M's beads	
3				(3)
4				
5				
6				What colour
7				
8				uh?
9				
10	Picks up bead to thread			
11	→me/camera			That's green
12	→at beads			
13				in
14	smiles		Touches M's L hand	and
15	Handles beads and thread	laughs	Laughs	
16				
17				
18				
19				You cannot
20				You cannot put it through
21	Uses R hand to look in box			
22				Get the green one
23			Shakes head	Green. Green
24				Green
25				
26				
27				
28				Look for the green one
29				
30				Green one
31				green
32				
33				Where's green?
34				
35				
36				
37				
38				The one you were holding before. That was green
39				
40				
41				
42				
43				oh oh
44	Picks up white bead	Smiles	→ bead	That's not
45		Laughs		
46	Holds bead towards H		► bead	oh That's not green
47	Moves bead away from H		► bead ; Laughs	That's not green.
48	Moves bead towards H			
49			Picks up bead from box	This is green
50	Replaces bead in box		Holds bead for M to see	
51				OK
52			Puts bead back in box	Get the green one
53	Uses R hand to look in box			
54				

55				
56				
57				
58	Picks up bead		Laughs; turns away	
59			Turns back to M	
60				That's blue

Claude also makes an attempt at resistance, in Excerpt 5 in response to R's attempts to draw the conversation to a close with a very explicit *Have your lunch first, then we'll talk afterwards, hey?* (at 54-55). Claude takes another turn two seconds later, only to be told *Ok. Have your lunch first*. R has the last say and Claude has been unsuccessful in regaining control of the interaction.

Excerpt 5
Setting: dining room; lunchtime.
Participants: resident Claude (eating) and staff R (off screen feeding resident G).

Time (Secs)	Resident: non-verbal	Resident: verbal/vocal	Staff E: verbal
48.		(8)	
49.			Luke's getting married?
50.			
51.			
52.			
53.		Tomorrow morning	
54.			Yeah, ok. Have your lunch first, then we'll talk afterwards, hey?
55.			
56.			
57.		(5)	
58.	Nods and ← then → R		
59.			Ok.
60			Have your lunch first.
61.			
62	→ food; continues to feed himself		
63			Open your mouth, G

Sarah, like Hilary finds herself on occasion participating in interactions with which she has difficulties. Sarah appears to adopt a different strategy of coping though: she always takes turns even if she has to use minimal or inappropriate responses. Sylvia

may be aware of the likelihood of this happening; when talking to Sarah about the important subject of her impending hospital visit (Excerpt 6). Sarah gives minimal responses (*yeah* at 4, *erm* at 19), looks away (at 5 and 10) and changes the subject (at 5 and 10). Sylvia switches from the closed question she starts with (*Do you know why…*) to open ones: *Why? Why are you going to the hospital…what are you going to the hospital for?* which oblige a fuller response. Sarah is actually unable to provide any of the information, and Sylvia ends up providing it. According to Ng and Bradac (1993) it is the proportion of speakership turns rather than size of turn that confers influence in conversation. However, in Sarah's case, although turn taking tends to be fairly equitably distributed, her turns are often so minimal that they confer little or no control over the interaction. Sarah's repetition of single words may also serve the function of fulfilling a turn.

Excerpt 6
Setting: discussing impending hospital visit (discussion extends both before and after this excerpt and lasts 3 ½ minutes).
Participants: Resident Sarah and staff member Sylvia. Researcher behind camera.

Time (Secs)	Resident: non-verbal	Resident: verbal/vocal	Staff : non-verbal	Staff : verbal
1.				Do you know why you're going to the hospital?
2.				
3.				
4.		yeah		
5.	←	Devil!		why
6.				Why are you going to the hospital Sarah
7.	→Sylvia			Sarah, listen to me
8.				
9.				Why are you going to the hospital
10.	←	hoover!		
11.				
12.				
13.				
14.				Sarah
15.	→Sylvia			On Thursday you're going to the hospital
16.				
17.				
18.				What are you going to the hospital for

19.		erm		
20.				
21.			Points to own teeth	teeth
22.				
23.				
24.		teeth		
25.				yeah
26.				
27.				You're going to have your teeth looked at
28.				
29.				Yeah
30.				They're going to have a look at your teeth

Mary has very much less speech than Sarah, so is perhaps in a weaker position regarding fulfilling obligations to take turns. Mary sometimes struggles to provide responses, especially when a very specific response is called for, as in Excerpt 7. Cheryl is asking test questions, to which a pointing response using the communication book is demanded. Mary is cooperative, within her cognitive limitations, and Cheryl is sensitive to these limitations; when a response is not forthcoming Cheryl gives more time, more cues to prompt a response and more information to assist Mary e.g. W*here's the hairdressers Mary. Where's the hairdressers? Where do you have your haircut? Show me.* Although participants collaborate in this interaction, Mary is not permitted to *not* respond; Cheryl is in control, obliging a response and delimiting the nature of the response.

Excerpt 7
Setting: living room; on sofa looking at communication book
Participants: resident Mary and staff members Francine (face obscured) and Cheryl.

Time Secs	Resident: non-verbal	Res't: verbal /vocal	Staff Francine: non-verbal	Staff F: verbal	Staff Cheryl: verbal	Staff C: non-verbal
1.			holds & → book		Where's the hairdressers Mary?	Face off-screen
2.	Smiles; ► own chin	laughs				
3.					Where's the hairdressers?	
4.					Where do you have your	
5.					hair cut?	
6.					Show me	
7.						
8.	► item in book				There you go.	
9.		laughs				
10.					Where do we go shopping?	
11.						
12.	► toward chin					
13.	► item in book				Where do we go…	→ book
14.	→book		→C, →book		Brilliant!	smiles; lifts eyebrows
15.	Hand hovers over book					
16.					And	
17.					Where do we go	
18.						
19.					Where do we go to buy your magazine	→Mary
20.						→book
21.						
22.						→ Mary
23.				Where		
24.						
25.						←
26.	→ and ► item in book					→ book
27.			→C, → book		Yes!	→Mary

A similar set of circumstances pertained in Excerpt 8; this time it was Francine who was looking at the communication book with Mary and directing her to point to specific items. The interaction appears a lot less collaborative however, and the two participants compete for control. At the start of the transcribed excerpt Mary is initiating by pointing to items in the book (at 1, 5 and 11) and Francine responds verbally. However at 15, Francine retains speakership at a point that could have been the end of her turn, by removing Mary's pointing hand and pointing to something else, saying *Who is this one?* Mary does not complete this adjacency pair but nevertheless takes a turn at 19 by pointing to something else. Francine persists in pointing to her own selection and repeating *This one. Look at this one*. The tone

of competitiveness continues when Mary does not respond to *And this one* (at 41); Francine follows it up with *Hey?*; Mary still does not respond so Francine taps her hand at 45. Francine then does not give Mary time to respond, but answers her own question by naming the person pointed to. This is a battle over whose topic is ratified (Diamond 1996) but it is also about who gets to initiate and have their turn responded to. Francine finds herself unable to retain control verbally, so resorts to physical means; she not only holds the book and controls the turning of pages (at 58, and later at 1:36 and 2:08) but also pulls Mary's hand away from it (at 15 and 30). The contrast between this excerpt and the one above involving Cheryl is notable and suggests that any difficulties with turn taking are not the result of any incompetence on Mary's part. Wider factors must account for the difference, for example the relationships between Mary and others, and possibly the difference in cultural background between Mary and Francine who is a recent immigrant from Jamaica.

Excerpt 8
Setting: living room: researcher behind camera
Participants: resident Mary and staff Francine sat next to each other looking at communication book.

Time (Secs)	Mary : non-verbal	Mary: verbal /vocal	Staff : non-verbal	Staff : verbal
1.	→ and ► item in book	(1)	Holds book	
2.			→ and ► same item	Who is this
3.				Mm?
4.				Cheryl
5.	→ and ► another item			
6.				
7.			Pulls M's hand away	Let me see
8.			Leans towards book then back	This one
9.				Muriel
10.				I don't know Muriel

11.	→ and ► item in book			
12.				Cheryl
13.				
14.				You know Cheryl
15.			Pulls M's hand off book	
16.			→ and ► another item	And who is this one?
17.				
18.				
19.	→ and ► different item			
20.			→ and ► same item as above	This one
21.	→and ► item indicated by F			Look at this one
22.				Ruby
23.		(2)		
24.				Yeah
25.				
26.	→ and ► item 'Cheryl'			
27.			Moves book	
28.				
29.				
30.			Pushes M's hand aside	Who is this
31.	→ researcher, smiles	Laughs	→ and ► item in book	Laughs
32.			→ researcher, smiles	
33.				
34.			→ book	
35.				
36.	→ and ► item indicated by F			
37.				
38.				Oh you know Claude
39.				Laughs
40.			Taps M's hand	Mary
41.	→ book		→ and ► item in book	And this one
42.				
43.				Hey?
44.	→ researcher			
45.			Taps M's hand	It's Gwen
46.			→ and ► to Gwen	
47.	→ Gwen			
48.	→ and ► book		→ Mary	
49.				Gwen
50.			→ picture of Gwen in book	
51.				
52.	→ and ► several items			Muriel I don't know Muriel
53.				
54.				
55.	→ and ► item			
56.			→ Mary then book; laughs	Cheryl
57.				You keep pointing to Cheryl
58.			Lifts page ready to turn it	
59.				

Turn taking typically occurs in conversation with split second timing. The sometimes slow and uneven pace of conversation involving the residents can make turn taking difficult to interpret, as in Excerpt 9. Claude's gagging (thought by staff

to be a behaviour used to attract attention) at second 1 may or may not prompt R's *Claude* (at 7) and *You all right Claude* (at 11). He responds only by looking at her but when R says *Do you want me to feed you?* He provides a full and appropriate response: *Let me do it* (at 16). He completes the second but not the first adjacency pair initiated by R. Neither Claude's nor R's turns are taken promptly all of the time; Claude's *I want a word with you* (at 29) receives R's reply four seconds later. This may be to do with R feeding another resident during this conversation.

Excerpt 9
Setting: lunchtime, at the dining table. Researcher behind camera.
Participants: Resident Claude; resident G and staff member R off screen.

Time Secs	Resident: non-verbal	Resident: verbal/vocal	Staff E: verbal
1.	Audibly chokes/gags on food; →R		
2.			Open your mouth, G
3.	→food on his plate		
4.			
5.			
6.			
7.			Claude!
8.	Starts to put spoonful of food in mouth		
9.			
10.	Finishes putting food in mouth		
11.			You all right, Claude?
12.	→R		
13.			
14.			Do you want me to feed you?
15.			
16.		Let me do it	
17.	→food		Go on then
18.			You've been doing a
19.			Good job there.
20.			
21.	→R	(3)	
22.			Uh?
23.			
24.			
25.			
26.			
27.		(1) getting married	
28.			Right, finish that off
29.		I want a word with you	
30.			

31.			
32.			
33.	→food		You say you want a word with me?

A number of cautious observations can be made based on the limited sample of data discussed above. All the residents can and do take turns in conversation and attempt to influence it, although their success in doing so may not be a function of the amount of speech they have. The degree of influence exercised would not appear to be equitably distributed. What appears to be the case is that any set of discourse rules governing turn-taking rights and obligations between staff and residents is complicated by the significant limitations in communicative competence experienced by the latter. It is likely that staff exercise more control through allocating speakership, but it may be that they often do so to promote and facilitate the residents' participation in interaction.

Whether apparent breaches of the rules (such as interruptions) are deliberate attempts at exercising power or the result of limited competence is not always easy to ascertain. Mainstream literature assumes competence in skills such as self selection, which according to Ng and Bradac (1993). "imposes considerable time pressure on the coordination of speakership and requires attentive listening to ongoing utterances" (p74). It is likely that some people with severe learning disabilities have difficulties with this, so interruptions may not necessarily be assumed to result in the perceived speaker influence that usually accompanies such rule breaking.

Timing is of great significance in the use of aided AAC because of the extended time needed to generate messages in many AAC systems, and this has implications for turn taking, and therefore of control of the conversation. Although timing is a potential issue, it did not appear to me to be particularly problematic for participants. It is possible that use of AAC by these people could reduce the degree of control that is possible, and this could act as a significant disincentive to its use.

The issues relating to turn taking clearly have relevance for who controls the immediate interaction, although caution is needed in drawing conclusions about any long term implications regarding dominance between residents and others. According to Diamond (1996) turn-taking is often *assumed* to be a key strategy through which participants exercise or seize power but she proposes that topic may be more meaningful for participants, and this is explored next.

Topic control

The raising of a topic requires turn taking strategies, so the two concepts are closely linked. Raising a topic puts the speaker in a vulnerable position: others may not ratify the topic or may reject the idea even if the topic does get ratified (Diamond 1996). If successful the speaker is in a powerful position; if unsuccessful the speaker may use strategies such as prompting, repeating or rewording in an attempt to get their topic accepted. As with turn taking, topic control is collaborative but may be asymmetrically so.

Typically in conversation, one participant offers a topic, the partner accepts or rejects it, and the first participant then elaborates the topic. Clearly the residents differ in their abilities in this regard, although all four are able to introduce and accept or reject topics, whether verbally or non-verbally. Elaborating a topic may be beyond the expressive abilities of Mary and Hilary who have very little speech and to a lesser extent Sarah and Claude. I start by demonstrating the considerable asymmetry in terms of who introduces topics, in the interaction involving Sarah.

Frequently, my conversations with Sarah involved confusing changes of topic, with topics often being repeatedly returned to by her. Usually in interaction each utterance is interpreted in the light of immediately previous turns (Ochs 1979). As Ochs points out, however, this assumption cannot be made about young children's interaction, nor, I would argue, about this resident's: her attention is frequently elsewhere, often she may not understand what her partner has said, and many of her turns may relate to *her* previous turn rather than that of her partner. Topics do not necessarily evolve sequentially, but rather are maintained in parallel. A conventional transcription layout which progresses chronologically from top to bottom gives the reader an impression of incompetence, but an alternative layout (see Excerpt 10), in which topics are developed in parallel columns suggests unconventional rather than incompetent topic control skills by Sarah.

In this excerpt Sarah initiates all six of the topics, although her introduction of 'ankles' at turn 11 is not taken up by me immediately: she tries again successfully at her next turn, 13. This suggests that Sarah has considerable control of the interaction. The possibility that Sarah is more able to initiate topics of her own

choosing, than to respond to those of others (a function of her learning disability and language impairment) may account for this feature. Although topic control is typically associated with the more powerful participant in conversation (Ng and Bradac 1993), as Sarah has demonstrated, this is not necessarily the position held by the more competent partner.

Claude's style of conversation demonstrates the same characteristic of sudden and surprising changes of topic, which I believe are also due primarily to his language impairment. Below, the topic of Gloria was already established.

> *Stephanie: have you known Gloria a long time?*
> *Claude: yes. In the hospital together… round the corner.*
> *Stephanie: who else did you know a long time? Mary?*
> *Claude: my brother's coming on Sunday.*

For both Sarah and Claude, continuation of the conversation seems to compel them to contribute in any way they can, even if this results in the communication partner having to cope with unconventional shifts in topic.

Excerpt 10
Participants: resident Sarah, researcher.

Turn	Column 1 Sylvia's pen	Column 2 Tea	Column 3 Table/chair	Column 4 Ankles/shoes	Column 5 Teddy	Column 6 Money
1	[unintell] pen					
2	Sylvia's pen					
3		Cup of tea.	No table.			
4			No table?			
5			Broke it.			
6			I thought they just moved it.			
7			[unintell]			
8			Moved it to the other room.			
9			No table there. Broke it.			
10			You like it better without the table?			
11			I got this chair.			
				Me ankles hurt. And me shoes hurt me. Them shoes.		
12			So the table			
13				There. [indicates her shoes]		
14				Yes there they are. Your shoes.		
			So who broke the table Sue?			
15			Broke it.			
16			Do you know who broke it? It wasn't you was it? [pause] Do you like it now it's gone?			
17			Yes.			
			That chair is mine. [points to wicker chair in corner]			
18			Which is your favourite chair?			
			[points to the special one she is in]			
			Is that the comfiest?			

And that's yours, isn't it?
[unintell] teddy bear. [points to it on her wicker chair.]
Sorry. The teddy bear?
Sleeping.
Sleeping? [laughs]
Me ankle
Is it feeling better now that Sylvia's given it a rub?
Yeah.
A pen. A pen look.
She'll be back in a minute; she's not far away is she?
Me ankle.
I got some money look [indicates her purse].
You got some money? In your purse? Oh right. Are you wealthy? Are you a rich woman?
Yeah.
Me ankle.
What are you going to spend your money on?
A book.
A colouring book?
Yeah.
Me shoes hurt me.
Sylvia said she'd buy you some new shoes.
[unintell]
Sorry?
My money in the bank.
Your money in the bank.
Letters. Where's Sylvia?
Sylvia's in the other room I think.

Mary, being predominantly non-verbal, exercises topic control through a different medium, but again does so abruptly. In Excerpt 11 the course of conversation largely follows Mary's gaze as she looks round the room, and points to things to which she wishes to draw my attention. Mary readily initiates a topic by pointing to something; this appears to occur at 12, 22 and 34 seconds. While providing her with some control over the interaction, this limits her topics to things that are physically present. It is predominantly the partner's responsibility to develop the topic, although Mary's vocalisations at 29 and 37 could be interpreted as attempts at topic continuation.

My initiation of topics tends to be less successful than Mary's, if success is interpreted as the partner's subsequent turn relating to the topic introduced. Mary does not ratify the topic (holidays) I raise at 7. Under normal rules of conversation this would be considered rude. It is possible that 'holidays' is a topic which Mary is unable to maintain since it has no referents present in the environment.

In interaction with Mary, the number of turns per topic tends to be few: for example, at 12-15 (excerpt 11) Mary looks at the hi-fi; I comment on this; she vocalises; I ask her a question. I then interpreted her looking away as Mary terminating this topic. It is hard to see how this topic could have continued without me providing more and more content, thereby increasing the asymmetry of the interaction.

Excerpt 11
Setting: living room, sat on adjacent easy chairs; music playing; the fish tank had recently been cleaned.
Participants: Mary (resident) and Stephanie (researcher, S). Other staff and residents (Sally) all off screen

Time secs	Resident: non-verbal	Res't: vocal	Researcher: non-verbal	Researcher: verbal
3	→ S; → and ► camera		→ M	
4				
5				
6				
7	←			You were telling me about holidays
8				
9				
10				
11				
12	→and ► hi-fi. Holds S's hand		Holds hand	
13	→ S		→ hi-fi then M	Are you pointing to the music?
14		(1)		
15			→ M	You like this tune?
16	→around room			
17				
18				
19				
20				
21				
22	→ fish tank		→& nods to fish tank	What about the fish?
23				
24				
25	→ and ► fish tank	(2)		
26	→ S			
27	→ S			They look a bit murky still, don't they?
28				
29		(2)		
30				
31				
32	→ around room			The water will go clear in a minute
34	→ and ► Sally		→ Sally.	
35				
36				
37	→ S	(3)	→ M; looks at Sally	Sally? (1) yeah

Diamond (1996) claims that a speaker who is successful in raising a topic is in a powerful position. However, we cannot draw quite the same conclusions from this data as Diamond does from hers. All three individuals who provided these examples

demonstrate the effective use of topic control strategies despite their linguistic or motor speech disadvantages. They do so not necessarily to exercise power through controlling the interaction, but also to maintain the interaction itself. While the unconventional manner of topic control exercised by these residents might be regarded as lacking in competence, paradoxically it could also indicate a level of pragmatic competence that exceeds our expectations.

From addressee to topic

I often observed conversations about a resident being carried on in their presence, but not involving them. This phenomenon is a result of both the topic control and turn taking behaviours of participants. The distinction between the addressee and the hearer, receiver or audience of a message is made within ethnography of communication (Hymes 1994) and this is what characterises these pieces of interaction. It is not usual for someone who is the topic of conversation to be able to overhear it, except in situations of asymmetrical power, such as conversations regarding children, or, as in this data, residents. Such conversations in effect silence the resident who is not permitted to participate. At the same time, some residents in fact may not understand and may not be able to participate, although I present here examples pertaining to some residents who probably do and could.

Many of these conversations demonstrated very close dovetailing of interactions *with* and *about* a resident. Staff often made very rapid shifts in addressee within

their interactional turns; these shifts are identifiable by changes in tone of voice, eye gaze, grammar, vocabulary and topic.

In the following example both vocabulary and tone of voice mark out the utterances that were directed to the resident (in bold) who was also present when I interviewed a staff member:

> *No, it is a life skill. She could find herself-* ***ah! That's a big bunny!*** *[laughs]- she could find herself, you know, with no one … So she's not going to be really dependent on other people, you see.* ***Oh, he's a lovely doggy, he is, he's a lovely dog.***

In Excerpt 12, when Debbie was asking Sarah a string of test questions regarding the names of her children, Debbie's evaluative statements (at 16 and 24-25) were accompanied by eye contact with me or Sylvia (another staff member); the personal pronouns used also changed from *you* to *she*.

Excerpt 12
Setting: dining kitchen
Participants: resident Sarah and staff Debbie; Sylvia and researcher (R) off screen.

Time Secs	Resident: non-verbal	Res't: verbal	Sylvia: verbal	Debbie: non-verbal	Debbie : verbal
1.	→ book			→ at her	So who are they? What's their names?
2.	→ Debbie; ←				
3.	→ Debbie				
4.					Karen
5.		Karen			
6.					
7.					
8.					Leanne
9.		'anne			
10.					And
11.					Caroline
12.	←	'roline			
13.	→ Debbie			Laughs	
14.			Yeah, you remember		
15.			them don't you Sarah		
16.					And she remembers
17.				→ Sylvia	(3)

18.				→ Sarah	What was his name?
19.					
20.		Um			
21.					He gave you a haircut
22.	← ; → Debbie		Matthew? (whisper)		
23.		Matthew		Nods head	
24.				→ R, nods, smiles	She's got a good memory, she does
25.					
26.				→ Sarah	
27.					
28.					Hairdressers, yeah
29.					What did he do?
30.	→ Sylvia	(2)			He cut your hair
31.					
32.	←				Do you remember?
33.					
34.					And you went
35.					to my house didn't you?
36.		yeah			
37.	→ Debbie				And what did you have, you had a cup of tea and?
38.					
39.					
40.		Biscuits			
41.				→ R, smiles	Yeah biscuits

A change in pronoun use also characterised the following two utterances made by staff:

Look at her pushing me away. You want me to sit over there.

And:

He was slow eating this morning, wasn't you Dave?

These grammatical switches in which the resident is the subject, then the addressee, suggests that staff have a difficulty: they try not to talk about clients in front of them, but often have to. They get round this by addressing the client, while casting their colleague into the role of audience.

The extent to which residents are aware that they are suddenly no longer the addressee of an utterance is a matter of speculation. It is quite possible that they do not always pick up on what may be quite subtle cues indicating a change in addressee. An interesting paradox frequently occurs: staff I spoke to declare a belief

in the residents understanding what is said to them, or the need to work on this assumption and of treating them as you or I would want to be treated. And yet I overheard staff say many things that might be considered tactless; one staff member told me *he has the brain of a 10 year old* within earshot of the resident she was referring to.

Staff discourse was frequently centred on the topic of a resident's behaviour. In the next excerpt, I had asked Cheryl about the change in furniture.

> *Cheryl: you know why? Madam here [indicates Mary] would sit in the chair over there by the fish tank and kept tapping on the glass. Thought she was going to break the tank. But she was crafty; she wouldn't do it when anyone was around. What are you like Mary? Yes, I'm talking about you.*

That it is usual for staff to refer to the behaviour of residents in their presence but not the other way round, is made striking by Claude's tendency to do so. This is discussed below, in terms of Claude's use of staff discourses.

I rarely came across instances in which staff showed an awareness of the potential of their overheard comments to cause offence to a resident. The following incident took place while Christmas shopping, and was described in my field notes:

> *We went to buy a razor. I expressed amazement that some of them cost over £150. Judy said that was how much her husband's cost.*
> *Judy: But I wouldn't spend that much on Claude [to me]; I would, Claude…[to Claude]*
> *She wasn't joking, was clearly aware of how her comment would come across to the person it was about, but didn't really offer any explanation or apology. She ended up choosing, not the cheapest, but one costing about £60. So she clearly wouldn't spend that amount on Claude.*

There were more positive interactions too, in which efforts appear to have been made to involve a resident in a conversation about them (in which their participation would otherwise be limited). An example is Excerpt 13 in which Sylvia is telling Debbie an anecdote about and with Sarah; they both share the joke with Debbie.

Excerpt 13
Setting: kitchen
Participants: resident Sarah, staff members Sylvia who is recounting a story to Debbie (off screen)

Time Secs	Resident: non-verbal	Resident: verbal/vocal	Sylvia : non-verbal	Sylvia : verbal
1.	→ Debbie		→ Debbie	I said Sarah what is the matter and she said nothing.
2.	→ her colouring book			
3.		laughs		
4.				
5.				
6.			←	
7.				
8.	→ Sylvia		→ Debbie [stern expression]	In the end I went [loud voice] Sarah! Go to sleep!
9.			→ Sarah [smiles]	
10.				
11.				
12.	→ Debbie			
13.		Laughs		Didn't I
14.				Huh?
15.		Yeah!		
16.				Yeah
17.				

Evaluations of a resident may indicate where the power lies in the relationship, but these too can be of a positive nature, as when Debbie comments on Sarah's good memory in Excerpt 12 (see p132-3).

Staff demonstrated limited awareness of the excluding effects of these switches between *talking with* and *talking about* an individual, but there appeared to be a high degree of acceptance on the part of residents. Once again, this characteristic

has roots in and maintains asymmetry both in power relations and in communicative competence between the two groups.

Discourses that exclude

Residents are also excluded from conversation that goes on around them but which is not necessarily about them. This may occur simply because their communication skills are not adequate for participating in the often fast paced interaction maintained by staff (although Sarah in particular was observed to attempt to join such conversations). Exclusion may also occur through the staff's use of specific discourses, usually about the residents and the running of the home. (I use the term discourse to refer to the taken for granted ways of doing and describing activity, from a particular perspective.) That such discourse does not generally involve the residents is emphasised by the exception of Claude.

On one occasion Claude remarked to me (in Mary's presence):

> *Tried to do it! Capable. Ca- ca- ca-. Capable of doing that. Mary. She's not lazy. Capable of doing that, Mary.*

On other occasions he told me *Mary got into trouble yesterday* and *I'm going to stop her doing that*. Such utterances formed a pattern: Claude's use of styles of discourse normally reserved for staff contributed to his acknowledged role as *honorary staff member* (home manager's words). This enabled him to be involved, at a superficial level, in conversations with staff that other residents could not participate in. As the following example shows, the staff tended to go along with the

pretence (despite, in this case, an awareness of his inability to provide the help he was offering).

> *Claude: I'm going to help with the ironing*
> *Rula: oh, promises promises!*
> *Claude: it's my duty*
> *Rula: oh, it's your duty is it? All right then, go and do the ironing before you go to the pictures.*
> *Claude: I'll do it when I come back.*
> *Rula: oh, you're not daft are you?*

Staff appear to be permitting Claude to act out a role of *the boss*. The home manager told me that when Claude engages in these discourses he is *showing his authority*. She believes he is encouraged by staff as it is amusing or because it gives him a form of identity. What is unusual about these examples is that Claude is not appropriately authorized (Bourdieu 1977) to make utterances such as these (offers of help and reprimanding other residents). The conventions of such authority are social, not linguistic (Thompson 1991): engaging in the discourses does not in itself confer the authority. However, in the case of the institution of residential care in which Claude finds himself, there is an additional set of conditions, not encompassed by Bourdieu's theory: that is the reality of the disabilities experienced by residents such as Claude. His use of staff discourses is not recognised as a threat since there is no possibility of change. This concept of authority is discussed further in the next chapter.

Claude's use of staff discourses may also mark himself out from the other residents. Many of the people with mild intellectual disability interviewed by Jahoda and Markova (2004) were said to use downward social comparison in order to reject "a

globally disabled identity" (p728). It seems very plausible that Claude too is attempting to reject the assumption of total dependency brought about by his residency in the care home.

The suggestion that staff approve of or support Claude's creation of the role *honorary staff member* and even help him develop it through discourse is explained succinctly by Diamond (1996, p115): "One's identity is created not only by the individual, but by the audience which receives, acknowledges and responds to the identification. One's identity is contingent upon it being acknowledged and ratified by those to whom one presents it." This point is made by Ferguson (1994) in terms of group membership. Non-disabled partners confer membership, as illustrated by stories that attribute thinking to the person, see individuality in them, view them as reciprocating and define a social place for them.

Findings: Part 2

During the collection of data in the field, I was struck by how much of the interaction between staff and residents was aimed at getting others to do things; hence the emergence of the codes 'requesting' and 'directives'. Rather than identifying discrete features of interaction, these codes actually cover a continuum of strength or intensity, described by Saville-Troike (2003) as ranging from demand, request, suggestion, hint, to entreaty. Together, the two codes identify examples of the 'activity exchange' (Fairclough 2003) although they are not always easy to recognise. Neither of my codes relates closely to a particular grammatical

form and identifying them depends to a great extent on the interpretation made by the recipient, as evidenced by subsequent interactive events.

There is a considerable body of literature regarding purposes such as requesting and directing, within the interaction between parents/carers and children/adults with communication impairment. Bradshaw's review states that in communication with adults with learning disabilities, most acts are comments and requests and most are directive in terms of function (Bradshaw 2001). Likewise, McConkey et al. (1999) found that questions and directives to adults with intellectual impairments were favoured by staff. Similar findings pertain to children with disabilities and their parents. Conti-Ramsden and Dykins (1991) found that mothers of children with specific language impairment use more directives (interrogatives and imperatives) than when interacting with their normally developing children.

In contrast with the above findings, the narrow range of communicative functions commonly found amongst AAC users is also typically skewed towards requesting. Udwin and Yule (1991b) say that requesting action is one of only four functions produced frequently (accounting for 80% of interaction) by children with cerebral palsy using AAC.

From the CDA perspective the manner in which requests are made is very indicative of the power relationship between participants and is closely related to politeness conventions, and this theme is covered later in this chapter. "A person with less power in an asymmetrical relationship does not give orders to a person with more, and a person with more power does not beg" (Saville-Troike 2003, p258).

Residents' requests for action

Identifying an interactional turn as a request is not always easy even when it is made verbally. In seconds 1-9 of Excerpt 14 in which Sarah and Mick are cleaning her room, Sarah says *my shoes, there,* which Mick may interpret as a request to move them, since that is what he then does, although his verbal response *I know it's your shoes* implies that he thinks Sarah is merely drawing his attention to them.

Excerpt 14
Setting: bedroom, cleaning it.
Participants: resident Sarah, sat in armchair, and staff Mick; researcher behind camera.

Time Secs	Resident: non-verbal	Resident: verbal/vocal	Staff : non-verbal	Staff : verbal
1.	[face obscured by M]	My shoes, there	Moves wheelchair towards S	
2.				
3.				
4.	→ researcher/camera		Takes shoes off chair	I know it's your shoes
5.		Shoes		
6.				
7.			puts shoes on floor	
8.				Just plonked on there
9.		My shoes		

The difficulty in recognising requests is even greater when a participant does not use any speech. Here, Mary initiates an interaction when she attracts Cheryl's attention, pointing to the banana in her hand.

Cheryl: Eat it then.
Mary: [points to a can of pop on the table]
Cheryl: No. Leave that alone. Leave it. It isn't yours
Mary: [points to the tiger]
Stephanie: tiger

Mary: [vocalises to attract Cheryl's attention]
Cheryl: Yes Mary. It's a tiger

Of the three items that Mary indicates, the second is interpreted as a request for that item, even though a common pattern is for Mary to simply look around the room and point to draw someone's attention to those items. It is far from clear why Cheryl interprets Mary's point to the drink as a request.

Excerpt 15 is a clearer example of Mary issuing a request: I misunderstand her pointing and vocalising at first (seconds 3-4) but when she repeats it (7) and I suggest she is asking for tea, her gesture towards her mouth (11) and absence of repetition indicates that my interpretation was correct.

Excerpt 15
Setting: dining room
Participants: resident Mary, researcher.

Time Secs	Resident: non-verbal	Resident: verbal/vocal	Researcher: non-verbal	Researcher: verbal
1.	► kitchen		→ Mary	
2.		(1)		
3.			→ Eunice/kitchen	Eunice
4.			→ Mary	You're pointing to Eunice?
5.				
6.				
7.		(1)		
8.				Oh, tea
9.				
10.				
11.	Gestures towards mouth			

Hilary, like Mary is predominantly non-verbal but can make very clear requests on occasion, such as in Excerpt 16. Hilary's initial point and vocalisation is clearly interpreted by Michelle as a request for magazines, inviting Hilary to *show me*.

Excerpt 16
Setting: office
Participants: resident Hilary and staff Michelle (mostly off screen); camera hand held by researcher.

Time (Secs)	Resident: non-verbal	Resident: verbal/vocal	Staff : non-verbal	Staff : verbal
36.	► Shelf	Babby		
37.				
38.		Nee!		Where
39.				
40.		Nee		You come and show Michelle
41.				
42.	Walks towards shelf			You come and show me what it is
43.				

Sarah is the only resident for whom I have recordings of a substantial number of requests made verbally; she does so typically very directly. For example:

Sarah: I want a cup of tea.
Stephanie: You want a cup of tea. Shall I put the kettle on?
Sarah: Yes.

Explicit directives can be seen as impolite and as signalling power over the recipient (Hatton 1998) so it is perhaps surprising that many of the requests made verbally by residents lack politeness terminology to mitigate (Ng and Bradac 1993) their confrontational nature. This may be because even those residents with considerable amounts of speech have reduced competence in the use of finely nuanced mitigation devices (Malone 1997). It is likely that residents may be frequently excused for the absence of politeness conventions for this reason, as I did in the above example.

Claude, in the next excerpt, is not treated so leniently:

Claude: when's Cheryl on?
Steph: I don't know
Claude: then go and look at the rota

R: I have two hands there and two legs!

R teasingly indicated her limbs as if to demonstrate that she can't do several things at once. Claude's direct command has the potential to offend because of his relatively powerless status.

Sarah's speech can be very repetitive. In the case of requests, this may be because they are not always granted immediately (or at all, in some cases). In the following excerpt (from a very extended conversation), I interpret Sarah's *too warm* as a request, although Jane treats Sarah's utterance as a comment on the current state of affairs possibly because she is not willing to do something about it (she was busy cooking at the time).

Sarah: too warm
Steph: you're too warm?
Sarah: yeah. Too warm Pat. Jean!
Steph: [to Jane] I think it's warm in this corner as she is right between two radiators.
Jane: yes.
Steph: warmer than the middle of the room.
Sarah: Jean.
Jane: yes.
Sarah: Jean.
Jane: yes.
Sarah: Too warm.
Jane: I know.

Sarah's request could be interpreted as indirect and therefore more likely to elicit a response; however, her utterance is less linguistically complex than the various explicit alternatives e.g. *Help me take my cardigan off* or *Turn the radiator down*. It

may therefore be the case that Jane does not interpret Sarah's version *Too warm* as polite, but as linguistically unsophisticated. Indirectness as a mitigation device is further discussed below, in its use by staff.

Staff's requests for action

Staff are often directive towards residents in order to achieve a task associated with their care needs:

> *Meera: Come on, sit up.*
> *Lisa: ( ) sit you up, then Sarah. That's it. [brings cushions and repositions Sarah]*
> *Lisa: that's lovely.*
> *Meera: well done. You've got pink socks on! Ooh!*
> *Lisa: and again.*
> *Meera: can I just have a look please? [rolls up Sarah's trouser legs to look at her swollen ankles] oh, these are better.*
> *Lisa: sit up Sarah, sit up.*

Mick's frequent use of directives in Excerpt 17 (at seconds 10, 18, 19, 23, 25, 34, 42 and 49/50) also seems to be associated with the need to get the job done; he also provided physical direction and facilitation. The purpose of the activity was to facilitate Sarah cleaning her room as part of her college course work. Afterwards, I asked Mick what Sarah gets out of such an activity. '*It develops her independence'*. Even though you need to help her do it? '*Yes, because it involves her, gives her a bit of independence. Otherwise she just sits and colours all day.'*

Excerpt 17
Setting: bedroom, cleaning it.
Participants: resident Sarah, sat in armchair, and staff Mick; researcher behind camera.

Time Secs	Resident: non-verbal	Resident: verbal/vocal	Staff : non-verbal	Staff : verbal
1.	[face obscured by M]	My shoes, there	Moves wheelchair towards S	
2.				
3.				
4.	→ researcher/camera		Takes shoes off chair	I know it's your shoes
5.		Shoes		
6.				
7.			puts shoes on floor	
8.				Just plonked on there
9.		My shoes		
10.	[face obscured by M]		Picks up spray bottle	Are you going to spray your chair?
11.				
12.		My shoes		
13.			Moves chair closer to S	
14.				
15.			Bends over S	
16.	Takes hold of bottle		Offers bottle to S	Now
17.	Holds bottle			
18.				This bit here
19.			Holds bottle and trigger	This finger here
20.				
21.			Fiddles with bottle and S's finger	That's it
22.				
23.	→ wheelchair			And just spray the chair
24.	attempts to spray		Squeezes trigger	
25.			Puts hand over S's hand and squeezes	Like that
26.				
27.				
28.		Ah!		
29.				
30.			Releases bottle Continues bending over S	Ok?
31.				
32.				
33.				
34.			Takes bottle out of S's hands	Like this, look.
35.	→ wheelchair	Aye!	Sprays chair vigorously	
36.				
37.				Give your chair a good airing
38.				
39.				
40.				Eh?
41.				
42.				Like that
43.		(2)	Moves wheelchair away	
44.				Smells nice now
45.				
46.		Hey		
47.	→ wheelchair			Hey
48.				
49.				Shall we do this chair

50.	→ dining chair		Pulls S's chair across room	over 'ere?
51.		Yeah		
52.				
53.				Same way
54.			Pushes S's chair towards dining chair	
55.		(2)		
56.				
57.				Ey?
58.		Hey		

Some of Mick's utterances have more of the character of a commentary e.g. at 44, *smells nice now*; at seconds 37/38 *Give your chair a good airing* could be either directive or a comment. Two of the categories used by Corsaro (1979) regarding adults' interactions with young children are the "directive question" (when grammatically interrogative) and the "directive" (when grammatically imperative), both of which are used to control the behaviour of the child, and both of which are illustrated here. Many of Mick's utterances appear to demonstrate a metaphorical relationship (Fairclough, 2003) in which a particular grammatical form is used for a different function. For example, *are you going to spray the chair?* (10-11) probably functions as a demand, although is grammatically interrogative. *Shall we do this chair over 'ere?* (49-50) is another example. This metaphorical relationship has the effect of softening the demands Mick is making; he asks her what she is going to do or what they shall do next, in order to direct her to do so. This technique is often used to elicit compliance where more direct demands would not achieve this.

It could be predicted that directive utterances may often be prompted by the difficulties experienced by the resident with disabilities. However, in Excerpt 4 (see p115-6) Mary was not experiencing any difficulties when staff member Harry approached her while she was threading beads; nevertheless he proceeded to utter a

string of directive utterances (involving much repetition of *green*), many of which were grammatically imperative (22, 28, 52-53). She is unable or unwilling to cooperate with Harry's pedagogic agenda, in what for her is an enjoyable (and usually solitary) pastime. Harry's determination to get Mary to succeed in the task he has set her is also notable. It may be that Harry needs to save face in front of me (or just in front of Mary): he persists because to back down without having achieved Mary's compliance would result in loss of face. In other words, the risk mentioned above, does not in this case pay off for Harry.

A loss of face is experienced by Cheryl in the next excerpt (transcribed contemporaneously) when she says *Do what you like, it's your lunch*. Up until this point Cheryl had not permitted Mary to do what she liked:

> *Cheryl: use your knife please. Put it on this side [addressed to Mary]*
> *Claude: Mary got into trouble yesterday [addressed to researcher]*
> *Cheryl: yes, and the day before*
> *Claude: I'm going to stop her doing that*
> *Cheryl: use your knife Mary.*
> *Mary: [picked up knife but didn't use it]*
> *Cheryl: If Mary plays up this afternoon will you tell me? Are you going to phone me? [to Claude]*
> *Cheryl went to show Mary how to put the mash on the bread. There are then numerous exchanges in which Mary tried to do what she had been told, eventually abandoning the knife altogether. Then:*
> *Mary: do what you like, it's your lunch [to Mary]. Any other time I'd tell her off but I can't because there's bread under there; it's gone soggy [to researcher]*

Control of a resident's behaviour (when 'challenging behaviour' is a recognised issue regarding that individual) underlies the following extract:

Michelle: let's have a look [unintelligible]. Let me have a look. Go and have a look at that then but bring it back. Don't rip it.
[Hilary unsteadily takes recipe book to table]
Michelle: ooh careful. You're drunk!

Hilary initiates this exchange non-verbally, by going to the cupboard, an action which is interpreted by Michelle as requesting a cookery book. Michelle appears to have a number of goals: avoiding Hilary's challenging behaviour, ensuring her safety and limiting damage to the books. During discussions with Michelle, she described Hilary's interest in books and papers as an obsession, and taking such items away from her will often precipitate disruptive behaviour. Many of Michelle's utterances in the exchange from which this excerpt is taken are overtly controlling, and the majority are imperatives. Michelle only later uses a couple of hedges, where she adds a tentative *OK?* after her demand. This may be because taking papers away from Hilary is risky; mitigating the demand may be a strategy used by Michelle to avoid inadvertently prompting an outburst of challenging behaviour.

A staff member's desire for a resident to engage in constructive activity may be what motivates H's directive approach with Mary and Claude (especially from seconds 19 – 41) in Excerpt 18. Initially H is non-specific, suggesting they 'play' but later he refers directly to stacking, and moving certain bricks around; he also provides physical direction (66-71). Claude's use of the bricks typically lacks any apparent goal; it may be that H is uneasy with this, although overtly he is using the bricks to motivate Claude's participation in exercise.

Excerpt 18
Setting: living room
Participants: residents Claude (has several large Lego bricks on tray in front of him) and Mary (predominantly off screen and repeatedly trying to attract staff member H's attention); H massages Claude's shoulders continuously until second 61. Researcher behind camera.

Time (Secs)	Claude: non-verbal	Claude: verbal/vocal	Staff : non-verbal	Staff : verbal	Mary: vocal	Mary: non-verbal
1.	→ M; smiles; holds one brick		Kneels at side of C's chair; → C		mama	
2.						
3.	→ bricks, moves one around slowly		→ M; Stands behind C	Your mama?		
4.						
5.	→ (?TV?); smiles			Where's your mama?		
6.						
7.				Your mama is not here		
8.	→ bricks, moves one around					
9.						
10.						
11.					(1)	
12.			Bends over and → C			
13.						
14.	→ (?TV?);					
15.						
16.	→ bricks; moves one around				Laughs	Reaches towards bricks, picks one up and replaces it
17.						
18.	→ H			yeah	(3)	
19.	→ M		→ M	You play with Claude		
20.					Laughs	
21.						
22.						
23.					(2)	
24.	→ bricks; handles them slowly			You teach Claude how to stack these up		
25.						
26.						

27.			Bends over and → C and his bricks; briefly manipulates bricks	OK Claude	laughs	
28.				Show Mary how to stack these bricks		
29.						
30.						
31.						
32.				Stack it up		
33.			Resumes massage			
34.	→ M then → bricks					
35.				Come on		Reaches towards C's tray; picks up a brick and takes it
36.	→ M's hand					
37.			→ M, then → C	Just two		
38.				Two layers		
39.	→ bricks					
40.	←					Puts brick on top of another on C's tray
41.	→ M's hand; smiles			Come on		
42.			←			
43.			→ C		laughs	
44.	→ H then→ M's hand	(1) tried to do it, look		Ooh, see?		
45.			→ M, then → C			
46.	→ researcher	Tried to do it!	→ researcher			
47.			←			
48.			→ M	laughs		
49.						
50.	Head+eyes▶ M's hand					Reaches towards tray and handles bricks
51.	→ researcher	Capable				
52.						
53.	→ M's hand	Ca- ca- ca-				
54.	→ researcher					
55.	Head+eyes▶ M's hand	Capable of doing that				
56.	→ M then→ researcher	Mary				
57.		She's not lazy				
58.			→ C			

59.				That's nice		
60.	→ M					
61.	→ bricks			nice		
62.	→ H	Capable of doing that, Mary	Stops massage; moves to side of C; → bricks			
63.	→ bricks; handles bricks non-specifically					
64.						
65.						
66.			Nudges C's hands out of the way		Laughs	
67.		(2)		Please Claude		
68.				Claude		
69.			► one brick, then ► elsewhere on tray			
70.				Take this one out and put it there		
71.						
72.	Attempts to pick up brick indicated by H		Rests hand on chair; → bricks			
73.				OK		
74.				Try it		

Encouragement of activity of a certain type may also underlie Mick's comments to Sarah:

> *Sarah: look! [points to her colouring book]*
> *Mick: [moves crayon tin to look] a green mouse. Use another colour. Instead of green.*
> *Sarah: look! [points to picture]*
> *Mick: I know. It's lovely, but use another colour. You're always using green.*

This and the preceding section have been about residents and staff eliciting action from each other. The issue of the directness of such requests or directives has been commented on, but not explicitly in terms of politeness. In the next section, politeness is explored more fully.

Politeness

The theme of politeness is one addressed both by the coding of my data and by Critical Discourse Analysis. The discussion that follows focuses on uses of overt politeness markers such as 'please' and 'thank you', that are often associated with requests for action. According to Fairclough (1992b) the use of such conventions acknowledges and contributes to the reproduction of social and power relations. Graddol and Swann's work (1989) considers politeness from the perspective of gender; they suggest that although women may use more politeness indicators than men because of occupying a socially inferior position, this explanation may be simplistic: it assumes that a whole range of linguistic features can all fulfil a single function. As the discussion below demonstrates, participants appear to be achieving a number of aims in their use and non-use of *please* and *thank you.*

Unlike in most typical everyday conversation, in the residential homes the use of polite forms was often made the explicit topic of conversation, usually when a staff member drew attention to a resident not using appropriate forms and being asked to do so. For example:

> *Sarah: Claire.*
> *Claire: yes.*
> *Sarah: I've dropped it again*
> *Claire: you've dropped it again [picks it up]. What do you say? You're meant to say thank you.*

Prompts were often given using language not usually used to adults. I observed several staff to refer to *the magic word*:

Sarah: [dropped a crayon] (shouted very loud)

Claire: [went to pick it up for her] What's the magic word?

Claude at Bungalow A was also the recipient of staff requests to say *the magic word.* It is possible that a desire amongst staff to teach or reinforce the usual politeness practices of our culture, may account for some instances of attention being explicitly drawn to the use of politeness terms. However, the use of childish terminology such as *the magic word* clearly indicates that, in many instances, power was also being exercised possibly for disciplinary purposes.

The data contained examples of all four residents being requested by various staff members to say or sign *please* and *thank you*, and the next example indicates how used to this Sarah is:

Sarah: (toilet)

Stephanie: sorry?

Sarah: toilet please.

Stephanie: toilet?

Sarah's initial utterance *toilet* was not fully intelligible to me; my request for repetition or clarification, *sorry?* was interpreted by Sarah as a request for the word *please*.

Residents' use of politeness conventions

It has already been shown that Sarah has at least basic competence in the use of politeness terminology. Hilary is less able to demonstrate such competence. Excerpt 3 (p114) illustrates Hilary's use of the sign for *thank you.* Hilary's first two

vocalisations are, judging by their sound, probably not intentionally communicative but the third which sounded different probably accompanies her gesture/sign. It is not clear whether Hilary's gesture is imitation, or whether there is comprehension of its meaning although the accompanying eye contact and vocalisation might suggest meaningfulness. The amount of prompting and modelling that appeared necessary to achieve the sign was considerable, although it is impossible to tell whether Hilary would have signed *thank you* if this was not provided. I never observed Hilary to use this sign spontaneously.

Since we cannot assume that the residents are able to appropriately apply a full range of politeness conventions, should they wish to do so, interpretation of their failure to do so is far from straightforward. It is possible that a resident may on occasion deliberately omit polite terms as an act of resistance or provocation. This appears to be what is happening in Excerpt 19, in which Sarah repeats *Do it* at seconds 8, 12, and 15, without adding *please,* despite non-specific prompting to be more polite. As has already been demonstrated, Sarah is used to receiving and responding to such prompts, so is presumably choosing not to do so on this occasion. Sarah's act of resistance provokes a strong response from Sue, whose new topic of *manners* overrides Sarah's previous topic. Sarah's request for another cooking session is never acknowledged by Sue. Thus Sarah appears to have lost any power she had within this exchange. Staff certainly have the capacity for withholding desirables unless the resident complies with the staff's wishes, in this case not arranging more cooking unless it is requested politely; I am not sure whether this would ever happen in practice but the possibility may be enough to ensure certain behaviour from the residents.

Excerpt 19
Setting: kitchen, clearing up after cookery session
Participants: resident Sarah, staff Sue and researcher Stephanie behind camera

Time Secs	Resident: non-verbal	Res't: verbal /vocal	Staff : non-verbal	Staff : verbal	Researcher: verbal
1.	► and →	Look!			
2.	items on table				
3.	→ table				Are there still
4.					some ingredients
5.					left for next time?
6.					
7.					
8.		Do it Sue!	Approaches S with cloth		
9.					
10.			Wipes S's hands	Pardon?	
11.					
12.		Do it			
13.				What did you say?	
14.					
15.		Do it again			
16.				Have you got no	
17.		yes		manners today, no?	
18.					
19.			Wipes S's hands	Where's your	
20.		please		manners gone then?	
21.					
22.					
23.		(1)			
24.				When I ask you	
25.				something I always	
26.				say please, don't I?	
27.		please			

The data also demonstrate occasions in which staff do not insist on the use of politeness terms, possibly for a variety of reasons. It may either be a concession to a resident's limited communicative competence, it may be a reflection of the familiarity between staff and residents, or it may be a characteristic of the interaction of a particular resident-staff dyad, in which the staff member does not adopt a high status position of insisting on the resident's use of specific words.

Residents' use of polite forms frequently received comment from staff, for example when Mary was given a drink, said *thank you* and was told *well done.* Often this

occurred as part of an Initiate-Respond-Feedback (IRF) structure (identified by Sinclair and Coulthard in 1975 and cited in Fairclough 1992b, p153), a phenomenon discussed in the next section. Examples occur in Excerpts 3, 4, 7, 8, 12 and 17. The staff member's provision of comment or evaluation may be a feature of pedagogical discourse aimed at teaching or reinforcing the residents' use of politeness practices.

The data contained conflicting views amongst staff regarding residents' use of politeness terms. A student nurse, Laura, told me *I hate it when Claude says thank you; why should he need to thank people?* When I suggested it might be because he gets more attention if he is polite, Laura's fellow student, Karen agreed that *he's not stupid*, as if she believed that it was a conscious strategy on Claude's part. While it would generally be considered courteous to thank someone for doing something, even when it is their job to do so, the students' discomfort with residents' politeness may suggest an awareness of its effect of reinforcing existing power relations. In contrast, perhaps a more traditional view was being expressed by H, also in reference to Claude:

> *H: Claude is very grateful for the things you do for him. He remembers to say 'thank you' or 'I like you doing it'.*
> *Stephanie*: *Is that important?*
> H: *Yes. Because it means that he knows someone cares for him. He acknowledges it.*

Staffs' use of politeness conventions

Staff also used polite terms to residents but it is likely that this formed different patterns. In Excerpt 20, Michelle's use of *thank you* (verbally at seconds 6, 8, and 20 and by signing at 8) and by Mrs Hughes at 11, and the exaggerated intonation of her and Mrs Hughes' manner of thanking and praising Hilary are notable. This may be because Hilary's handing the items to Michelle was considered by her to be unusually appropriate and helpful behaviour. Hilary seems to enjoy the response she gets, vocalising and clapping enthusiastically. Michelle and Mrs. Hughes also look towards me, as if to ensure that I observed the moment; both appeared proud of Hilary's behaviour. This episode of cooperative behaviour did indeed seem unusual, and Michelle's response should be viewed relative to Hilary's typical behaviour, in which she frequently hides objects under sofa cushions. A possible interpretation of the repetitious pattern of thanking Hilary is that Michelle and Mrs Hughes wish to reward this behaviour of handing over objects, to encourage Hilary to do so again (for instance at line 28-29: *what else have you got for me?)*. The use of politeness in this example appears indicative of a significant power differential between Hilary on the one hand and her mother and carer on the other.

Excerpt 20
Setting: living room,
Participants: Hilary and her mother, Mrs Hughes seated on sofa playing with train set and Michelle stood in front; Researcher behind camera.

Time (Secs)	Resident: non-verbal	Resident: verbal/vocal	Staff : non-verbal	Staff : verbal	Mrs. Hughes: verbal	Mrs. Hughes: non-verbal
1.	Using a tissue to wipe spoon and cup	(1)		Well, Hilary		
2.					And I think there might be a piece	
3.						

4.	Hands all objects to Michelle.	(1, louder)			missing as well, so er	
5.			takes objects			
6.				Thank you		
7.				Hilary?		
8.	→ Mrs. H Claps vigorously		sign 'thank you'	Thank you!		
9.		(1, louder)				
10.		(1, loud, long)		Well done!		
11.		(1)			Thank you	
12.	→ to other side					
13.						
14.	Picks up glass				So, I think, er	
15.	Drinks from glass				Whether there was a piece missing	
16.						
17.						
18.					Whether this is why they were selling them	
19.	Hands glass to M		Reaches, takes glass			
20.				Thank you		
21.	Picks up magazine		→ Mrs H, nods			→ Michelle, smiles
22.	→ and handles magazine		→ Stephanie			→ Stephanie, smiles
23.			Smiles and nods			→Hilary
24.					Oh what a shame	
25.					laughs	
26.					laughs	→ Michelle
27.				(4)		
28.				What else have you got for me Hilary?		
29.						

Staffs' use of *please* and *thank you* to residents was often associated with seeking their cooperation with a care task, that is, with being directive. Explicit directives are easier to understand (Hatton 1998) but can be seen as impolite and as signalling

power over the recipient. Directives are frequently used by staff to residents, with or without politeness terminology to mitigate (Ng and Bradac 1993) their confrontational nature. If staff are assumed to hold a position of power relative to residents most of the time, the possibility is raised that staff may use polite forms for the purpose of depoliticisation (Ng and Bradac 1993). This means that the attempt at influence is made more palatable to the recipient. A similar idea is conceptualised by Bourdieu (1991) as censorship. Censorship operates in all everyday discourse and refers to how the way we speak is carefully tailored to the context (Thompson 1991); politeness is but one way in which censorship is manifested.

To summarise the theme of politeness, it appears that although both staff and residents frequently used *please* and *thank you* when interacting with each other, the data suggest asymmetry in the rules of discourse: staff may demand or prompt the use of politeness vocabulary from residents (deemed able to provide them) but residents do not demand the use of politeness vocabulary from staff. Paradoxically, staff may insist on politeness from residents in order to achieve greater symmetry, through reciprocal use of such terms. As Sue, in Excerpt 19 points out in response to Sarah's failure to say *please*: *When I ask you something I always say please, don't I?*

Critical interpretations of the use of polite terms differ for residents and staff. According to Ng and Bradac (1993) politeness is ambiguous; it can be seen as deferential and as indicating low speaker status, or it can be seen as effective and indicative of high status. One dimension of the situation that influences this

evaluation is whether politeness is used with other features of language which are (respectively) devalued, such as non-standard dialect, or are valued, such as a prestigious dialect. Another dimension is group membership: politeness is likely to be seen as powerless when used by members of a devalued out-group, but powerful when used by members of a valued in-group. It seems most likely that residents' use of (and staffs' expectation of their use of) politeness terms, should be regarded as indicative of their low status and membership of a devalued group, that of people with disabilities.

In the next and final section of this chapter, I explore the theme of the 'test question', a commonly occurring code applied to the data, and an aspect of interaction that has received critical analysis.

Test questions

My use of the code 'test questions' refers to occasions when a staff member asks a resident a question to which they know the answer. Such questions superficially resemble the knowledge exchange (Fairclough 2003); but there is no genuine exchange of information: the more able communicator both demands information, and already holds it. In this section I present data that indicate a variety of uses of such questions, but in all cases the interaction would more appropriately be described as an activity exchange (Fairclough 2003).

The test question is a widely recognised phenomenon, especially in adult-child interaction. Corsaro (1979) identifies six types of interrogative, of which the "question with answer" and the "leading question" are what I would call 'test questions' and I provide examples of both from my data. Sweidel (1989) has also observed that interaction involving non-vocal adults (not necessarily with learning disability) often resembles patterns found in adult-child interaction in which the partner's use of interrogatives enables a young child to participate. According to Corsaro, "The interrogative form is related to social control in that its employment by the speaker places a restriction on the possible responses of the addressee" (p378). I wished to explore reasons why staff might wish to use test questions.

A number of purposes for test questions emerged from the data; often they were used consciously within interaction. Staff member M, after allowing me to video her with Sarah, told me

> *I'm new. I don't know her very well. I don't know what her understanding's like. If you give clues and ideas you get more response. You get more conversation going... By listening to her responses, I get more knowledge about Sarah's understanding etc.*

She went on to say that she asks open questions so that simple yes/no answers are avoided, but the opportunity is given *to extend on it; with open questions you do get lots more response.*

The purpose of a sequence of test questions is often not evident from the interaction itself: I am unable to categorise the following excerpt, in which Mick sat by Sarah while he ate his lunch. Sarah was colouring:

S: what you got?

M: same as you had. What did you have?

S: salad

M: what are you colouring Sarah? Eh? What is it?

S; [laughs]

M; what is it Sarah? What's that?

S; what?

M; what you colouring? Look at the picture.

S; picture.

M; what is it? what's the picture of? What's that picture?

S; um

M; whale.

S; a little one.

Mick's response to Sarah's initial request for information (or is it actually a test question?!) is immediately followed by a test question. He then changes topic while maintaining the exchange structure (Fairclough 1992b) of test questions.

Pedagogic purpose of test questions

Test questions frequently form part of what Fairclough (1992b) refers to as 'question-response-assessment' cycles, a type of exchange similar to the Initiate-Respond-Feedback' (IRF) structures first identified by Sinclair and Coulthard in 1975 (cited in Fairclough 1992b, p153). The IRF structure is a device commonly used by teachers. Here is a simplified example from my own data (taken from Excerpts 7 and 22):

Cheryl: Where's the hairdressers, Mary?

Mary: [points to item in book]

Cheryl: There you go!

The IRF sequence is a type of 'exchange structure' (Fairclough 1992b; Fairclough 2001) in which the more powerful initiator is able to control the pattern of turn taking, the way in which the partner responds and also the overall topic. The examples of interaction I present here share these features with classroom interaction despite being from an entirely different social practice (provision of community residential care for adults with learning disabilities). The use of test questions suggests that similar pedagogic motivations may underlie both: monitoring knowledge and understanding, guiding learning and marking knowledge which is significant (Wells 1999). However, as Wells also points out, this type of discourse does not encourage the recipient to ask their own questions or initiate.

Excerpt 21 below is an extended transcript of Excerpt 7 from which the example above was taken; it contains five IRFs in under a minute (initiated at 1, 10, 17, 29, and 38); Mary is compliant with them all- she smiles, laughs and has her hand hovering ready to point when she gets the next question, although her failure to respond immediately prompts Cheryl to repeat the question (at seconds 3, 13, 45), or provide additional clues (4, 40) or some other prompt (second 6: *show me*). Cheryl is very much in control, of both the duration (the start and end points of the interaction are defined by Cheryl arriving and leaving the room) and the structure and content of this interaction.

Excerpt 21
Setting: living room; on sofa looking at communication book
Participants: resident Mary and staff members Francine (face obscured) and Cheryl.

Time Secs	Resident: non-verbal	Res't: verbal /vocal	Staff E: non-verbal	Staff E: verbal	Staff C: verbal	Staff C: non-verbal
1.			→book; holds book throughout		Where's the hairdressers, Mary?	Face off-screen
2.	Smiles; ► own chin	laughs				
3.					Where's the hair-dressers? Where do you have your hair cut?	
4.						
5.						
6.					Show me	
7.						
8.	► item in book				There you go.	
9.		laughs				
10.					Where do we go shopping?	
11.						
12.	► to chin					
13.	► item in book				Where do we go…	→ book
14.	→book		→C then book		Brilliant!	smiles; lifts eyebrows
15.	Hand hovers over book					
16.					And	
17.					Where do we go	
18.						
19.					Where do we go to buy your magazine?	→Mary
20.						→book
21.						
22.						→ Mary
23.				Where		
24.						
25.						←
26.	→ and ► item					→ book
27.			→C then book		Yes!	→Mary
28.	→C				And	→ book
29.	► to chin				Where do we go for	indicates book
30.					summat to eat?	→ Mary
31.						
32.						→ book
33.	► item in book					
34.	→C then book				That's it!	←→ book and Mary
35.	Hand hovers over book					
36.						
37.						
38.					And where's the club you used to go to?	
39.	► vaguely toward chin					
40.					Where's the * Club?	
41.	Hand hovers over book					
42.						
43.						
44.	► item in book					
45.					No, the * Club show me	
46.						
47.	► different item in book					
48.						→ book ► item in book
49.						
50.			► item in book			Walks away.
51.	► item indicated by C					
52.		laughs				

Mary is very used to using the communication book and other materials to point to in response to test questions; Sarah too is very familiar with this exchange structure. The following two transcripts arising from the fruit and vegetable delivery to Sarah's house occurred over a month apart; their similarity suggests a systematic pattern of this pedagogic style of interaction with this resident. Again evaluation of the resident's responses is a notable feature. Meera initiated the exchange, bringing a melon and a bunch of bananas over to Sarah; two other staff members then join in the exchange.

Meera: what's this Sarah?
Sarah: [no response]
Lisa: [whispered to S] banana and melon
Sarah: lemon.
Meera: it's the same colour. What colour is it? Try again.
Mick: [sings] 'they call you Mellow Yellow'
Sarah: yellow.
Meera: well done. [shows the bananas] what colour are the 'nanas'?
Sarah: green.
Meera: no they're not green. You know they're not green.

The test question format persists despite Meera's change of topic (from fruit to colours) in response to Sarah's incorrect *lemon*. It is possible that Sarah herself initiates the question-answer routine in the next excerpt by naming the bananas she is shown.

Lisa: look!
Sarah: 'nanas.
Lisa: well done. And? [holds up oranges]
Sarah: orange.
Lisa: oranges, yes. And? [holds up a large cooking apple]
Sarah: what's that?

Lisa: what is it? [brings it over for Sarah to have a closer look]
Sarah: ooh, look!
Lisa: what is it?
Sarah: herm. Apple.
Lisa: yeah, well done.
Sarah: apple. Apple.
Lisa: we got some mushrooms [unpacks them from the box]
Sarah: mushrooms.
Lisa: cabbage. [pause] cucumber.
Sarah: cabbage.
Lisa: and cucumber. [pause] lettuce. Tomatoes.

In the above excerpt, following three instances of the IRF pattern (bananas, oranges and apples) the sequence of test questions is discontinued and the interaction then involves word repetition. This may be because Lisa thinks Sarah does not know the names of the other vegetables. Interestingly Sarah's question (presumably for information) 'what's that?' was answered by Lisa also asking 'what is it?' (a test question).

Ensuring interaction is successful and sustained

Test questions limit an interaction to topics and content that the more competent partner believes the other can cope with. I suspect that the most common motivation behind the use of such questions in my data is the wish of the partner to ensure success. This is how I interpret Cheryl's use of test questions to Mary while she is looking at her communication book (see Excerpt 22 above).

Improving the chances of success in interaction may underlie the use of test questions with Sarah too, although she has a lot more speech than Mary. Correct interpretation of Sarah's numerous single word turns often depends upon considerable contextual knowledge; as a result, conversation with less well known partners is more prone to failure. Frequent use of test questions facilitates interaction, since the speaker has the necessary knowledge.

Test questions may facilitate the telling of a story that an individual would otherwise not be able to tell, as in Excerpt 12 (29 onwards). Debbie says to Sarah:

> *What did he do? He cut your hair. Do you remember? And you went to my house didn't you? And what did you have, you had a cup of tea and? Yeah biscuits.*

Debbie's utterances are what Corsaro (1979) would call the 'question with answer', a type of interrogative used by adults interacting with children. The communication partner is merely asked to provide confirmation (as at second 36: *yeah*), but no new information. In this example, Debbie moves to this pattern of interaction following failures to elicit information from Sarah. The use of questions in the telling of this story perhaps give a superficial impression of Sarah's participation in telling it, although her contributions are actually minimal. According to Corsaro (1979), the provision of both question and answer by the adult overcomes problems in establishing shared meaning; the example I give here does not appear to be primarily for this purpose, since Debbie as the more competent communicator has already established meaning through setting and controlling the topic of *hairdresser*.

In the following extract, staff member Jane also uses the "question with answer" (Corsaro 1979) to facilitate a conversation between me and Sarah.

Steph: you got some Robbie things as well didn't you?
Sarah: Robbie
Jane: yes. What did she get? She got some Robbie calendars.
Sarah: calendar.
Jane: and where are they?
Sarah: wall
Steph: on your wall?
Jane: yeah.
Sarah: calendar.
Jane: in fact I think you got three, didn't you?
Sarah: three.

Similarities can again be discerned between this piece of interaction and that between adults and young children, with regard to the use of tag questions (Corsaro 1979) by both me and Jane (*didn't you?).* Corsaro differentiates two possible purposes to tag questions: they can be used to involve the less able communicator in conversation or to check they understand the interaction; here the former seems to best explain what is happening. Sarah's confirmatory responses are restricted to this role by the tag question.

Testing knowledge and Facilitating recall

These two functions appear to motivate many interactions, although the two are hard to distinguish. In Excerpt 6 Sylvia asks a number of probe questions, about the forthcoming trip to hospital, both to test out what Sarah knows and to stimulate her memory of it:

Do you know why you're going to the hospital?

Why are you going to the hospital Sarah?

What are you going to the hospital for?

Another example is M talking to Sarah in Excerpt 22:

Excerpt 22
Setting: kitchen; a 'staged' interaction for me to video
Participants: staff member M (new to this bungalow) and Sarah

Time (Secs)	Sarah: non-verbal	Sarah: verbal/vocal	Staff M: non-verbal	Staff M : verbal
1.				Did you have a nice weekend
2.		yeah		
3.				What did you do
4.				
5.				Can you remember what you done over the weekend
6.				
7.				
8.		Yeah		
9.				Do you know what day it was on Sunday
10.				
11.		yeah		
12.				What day
13.				I'll give you a clue
14.				
15.		erm		
16.				
17.				
18.				
19.				Something to do with mothers
20.				
21.		Yeah		
22.				Something to do with mums
23.				
24.		erm		
25.				
26.				Can you remember
27.				Cos you bought-
28.				What did you buy for your mum
29.				
30.				
31.				
32.		(2)		
33.				Chocolates
34.				Chocolates
35.				It was Mother's Day
36.				wasn't it

In the next example Michelle appears to be either probing Hilary's recognition of where she is, or prompting it.

where are we Hilary?
where are we?
[H vocalises and points vaguely]
do you know where we are?
did you used to come here?
yes?
it's where you used to live on this site isn't it.

There is a progression evident in this extract: the first three very open questions fail to elicit the desired response so Michelle's next question is more leading (Corsaro 1979); this also fails to get a contribution from Hilary, so Michelle then answers her own question, adding a tag question to invite confirmation from Hilary.

Immediate recall seems to be being tested in the next sample, as Mick has just given Sarah the answer to the question:

Mick: go on. No, pick one up and use it. That'll do; that colour; pink. Pinky winky! [quiet, sing song voice] What is it? What colour?
Sarah: erm
Mick: What colour is it? [pause] Pink (quiet voice, intonation incomplete)
Sarah: pink
Mick: Pinky winky! [sing song voice]

It is very likely that test questions were occasionally used specifically because I was observing. This may be the case in the following example, in which Claire's failure to get Sarah to answer the questions results in Claire's use of the 'leading question' (Corsaro 1979) *Was it Mick?* which Sarah then confirms:

Claire: [to me] she's got a good memory.
[to Sarah] Who fell down the hole, Sarah?
Sarah: um, um.

Claire: when we went out for a meal?
Sarah: um, um.
Claire: have you forgotten? Was it Mick?
Sarah: Mick
Claire: [to me] she usually remembers that.

The same could be said about Sylvia's and Debbie's interaction with this resident in Excerpt 12.

In summary, I have identified three main reasons why staff use test questions with residents: to teach them, to facilitate interaction and to test, prompt or demonstrate a resident's recall. The distribution of this feature was wide amongst staff but my data contained few examples of test questions being used with Hilary or Claude, compared to Mary and Sarah. It is likely that Claude receives few test questions because he is able to sustain interaction in other ways, for example by relying on a degree of confabulation. Conversely Sarah, the other resident who has lots of speech, seems to receive many test questions because her conversational skills are so limited that she needs this support to help maintain her participation in interaction. Hilary is not very compliant with interactional agendas set by others: if interaction is to be successful it has to be on her terms; Mary however is very cooperative with the use of test questions and others find this a good way of interacting with her.

It is no surprise that test questions are prevalent in interactions with the residents; this prevalence is both a result of, and demonstrates the asymmetries in communicative competence and power. In this respect, parallels can be drawn with care giver-child interaction, in which the use of questions is often motivated by

'communicative distress': e.g. when the child is not attending or is unable to articulate a whole proposition independently (Ochs Keenan et al. 1983). Pennington and McConachie (1999) point out that the high proportion of questions used by mothers to their children with severe physical disability and motor speech disorders, while promoting immediate interaction, only does so by restricting the less able communicator to a largely responsive role. While questions oblige a response, they rely heavily on context so the child's conversational skills do not develop.

Test questions were not always straightforwardly recognisable. For example, what could be considered a test question at a both pragmatic and grammatical level may appear to serve different purposes. In the interaction between Hilary and her mother (Excerpt 23), the interrogatives Mrs Hughes uses may well be rhetorical, no response being expected: *What's inside the bag* (second 1) and *Ooh, what is it?* (12). Their purpose may be to encourage curiosity and engagement with the activity. *What's that? Train* (26-29) may be more helpfully considered as drawing Hilary's attention to the picture than testing out her knowledge. Hilary mostly ignores her mother, although it is difficult to tell whether Hilary's non-engagement with the interaction is a consequence of her limited attention, or whether it could be interpreted critically as a "defence mechanism" (Fairclough 1992a, p157) typically used by the less powerful participant in an asymmetrical encounter.

Excerpt 23
Setting: living room. Mrs Hughes has just given Hilary a present.
Participants: Hilary and Mrs Hughes (mother); researcher behind camera.

Time Secs	Resident: non-verbal	Resident: verbal/vocal	Mrs H : non-verbal	Mrs H : verbal
1.	takes box out of bag			What's inside the bag
2.				

3.				
4.				
5.				
6.		(1)		
7.				
8.				
9.	looks at box			
10.				
11.				
12.	Holds box up for researcher to see	(1)		Ooh, what is it?
13.				
14.				
15.	Handles box			
16.				Hilary
17.	Examines and attempts to open box	(1)	Gestures to turn box round	The wrong way round
18.				Turn it up-
19.				
20.				All the way
21.			Touches box and gestures	
22.				No that way
23.				
24.				Look
25.			→ and holds box	
26.			► picture on box	What's that?
27.				
28.				
29.				train
30.				It's a train
31.			Leans away and removes hands	You like trains don't you
32.				

The interaction continued with further questions from Mrs Hughes: *What does a train do Hilary?* (at 63) and *Does it go woo woo?* (at 67), which appeared to be attempts at eliciting participation from Hilary.

It is tempting to assert that I found no examples of residents asking test questions. But this rests on the assumption that staff members just never interpreted residents' utterances in this way. Mary's typical pointing behaviour, for example, in which she points then waits for a response from someone, could be viewed as a test question but this interpretation seems unlikely. In Bourdieu's terms, residents do not have the

authority to ask test questions, authority which is conferred by the social conditions (Thompson 1991) of the institutional setting.

Conclusions

Residents demonstrate considerable competence in interactional control through turn taking and topic control, giving them often substantial control over interaction, despite the limitations in their expressive communication skills. However, this control is often achieved by unconventional means, for example Claude's confabulation, Mary's pointing and Sarah's use of minimal responses. Staff may permit the breaking of the usual rules of conversation e.g. by allowing more time, or assisting the formulation of a response. This collaboration within conversation may be motivated by mutual desire to promote and maintain interaction (for example, when residents follow well rehearsed routines such as sequences of test questions). As well as collaboration the data demonstrate occasions when residents compete for the power most usually held by staff, for example, by forfeiting turns or omitting to use the expected terms of politeness. Constraining the interaction such that a resident is more likely to be able to participate is, however, still indicative of the greater power that staff have relative to residents. This power is also evident in the way residents are frequently excluded from interaction, even when it is about them. Long term, the control staff exercise within interaction with all four individuals is likely to contribute to inhibiting their learning of more sophisticated conversational

skills, skills that would necessitate the use of AAC. It is to this theme that I turn in the next chapter.

CHAPTER 6:

FINDINGS (PART 3: AAC)

None of the residents were observed to use AAC functionally (see p21 for discussion of this term) in their day to day interaction. AAC often formed the topic of my discussions with staff, however, reflecting my interest in its role within the setting of these residential homes. The first half of this chapter reports on my findings, firstly regarding the place of AAC in the homes, based on observations, interviews and documentation. I then go on to provide illustrations of how AAC seems to be perceived and used by both residents and staff, particularly in relation to a classification of the purposes of communication. The second half of the chapter begins with an exploration of how these data compare to the literature on AAC; I then bring a critical perspective to AAC use in a discussion of power relations between residents and staff. The potential for change in the current situation of AAC non-use is addressed in the next and final chapter.

The place of AAC in the homes and in the lives of the residents

Long Lane

This was the first site I visited but which I decided not to focus on. There was ample documentation setting out general aims regarding communication (including AAC) but also pertaining to specific individuals. One of the twelve "Aims and Objectives" at the home was "the right to a communication system to maximise potential". Files

relating to the four residents made references to various forms of AAC: Objects of Reference, Total Communication, Makaton signs, tactile cues, personal communication profiles and picture cards. Information was confusing and often contradictory and I saw very little evidence of any recommendations being acted on. The manager emphasised 'staff turn over' as a reason.

Number 34

None of the residents here had aided AAC systems. Hilary's mother believed that Hilary had never used symbols or pictures, and that she knew a few signs but did not use them meaningfully. Mrs Hughes did not know any signs herself. Hilary's file reported that she uses some Makaton signs such as *drink*, and understands the sign for *later*. It also reports that she uses signing to communicate frustration or anger (rubs her head aggressively). I suspect that some of Hilary's 'signs' might better be described as 'gestures', being idiosyncratic rather than part of a sign system. Nowhere in the file was there a comprehensive guide to signs or gestures she might use or understand. A staff member, Carl, told me that Makaton was not used widely in the hospital where Hilary had lived for most of her life. I observed Hilary's key worker, Michelle, use a few Makaton signs, possibly not accurately; her apparent desire to demonstrate their use made me suspect that what I was observing may not be representative of usual practice. This is despite a notice in the entrance hall of the home saying "YOU ARE COMING INTO A SIGNING HOME" depicted in text and Makaton symbols.

Bungalows A and B

Claude's verbal expression was better than that of any of the other residents at his home, Bungalow A; his manual dexterity permitted limited pointing but not gesture or sign. Mary (who moved from A to B while I was carrying out field work) was the only resident who appeared to have had any intervention regarding communication from SLT in recent years. She was also the only resident at any of the research sites who had an aided AAC system: a symbol communication book, kept on the coffee table in the communal sitting room. Several staff in Bungalow B to which Mary had recently moved were unaware of the existence of Mary's communication book; this is despite their acknowledgement that it could be especially useful to people who do not know her well. In terms of physical characteristics, Mary's communication book was a plastic A4 folder with clear plastic pockets. Mary's photo was in the front, followed by brief information in text and symbols introducing her and how she uses the book. There were then nine topic sections, such as people, places and activities; content appeared designed to facilitate the expression of needs and wants (Light 1988), described below. Most items were represented by photographs, with some use of symbols and all had accompanying text. Mary also used a small number of Makaton signs.

Number 32

I saw no evidence of any AAC systems in use by any of the staff or residents. None of the residents would typically be considered strong candidates for the introduction of aided AAC. With the exception of Sarah who was highly verbal, all the residents had profound and multiple disabilities and staff were aware of little intentional

communication. Many of the staff, however, had experience of and views about AAC.

In summary, all five of the homes were environments where I, as a speech and language therapist would predict there to be some potential for enhancing the communication of at least some of the residents, through AAC. It is likely that many of the residents would be unable to use aided AAC expressively, although Mary and Hilary in particular probably were able and motivated to do so.

How is AAC perceived?

My data contained a few pieces of interaction involving staff and residents using AAC, and numerous views and comments from staff made during interviews. Many of these related to the purposes that augmented communication systems can fulfil, and this is the subject of this next section. To structure this review of the data I have related my findings to the seminal classification proposed by Light in 1988, and still used by practitioners now. According to Light there are four purposes of communicative interactions (Light 1988, p76):

1. Communication of needs/wants
2. Information transfer
3. Social closeness
4. Social etiquette.

When communicating needs and wants, "the goal of the initiator is to regulate the behaviour of the partner to provide a desired object or to perform a desired action" (Light 1988, p76). This would appear to correspond closely with Fairclough's concept of the 'activity exchange' (Fairclough 2003) in Critical Discourse Analysis, although Light and Fairclough are unlikely to have been aware of each other's work. Light's second purpose, information transfer, closely relates to Fairclough's 'knowledge exchange' and this type of interaction has a wide scope in which content is important and much less predictable than that of the expression of needs and wants. In the third category (social closeness) the goal is to "establish, maintain, and/or develop an interpersonal relationship" (Light 1988, p77) in which content is less important than the maintenance of communication. Finally, Light (1988) described 'social etiquette' as aiming to "conform to social conventions of politeness"; this category consists of a relatively small and predictable set of potential utterances.

1. Communication of needs and wants

According to Light (1988) this function often receives emphasis in the communication of people with physical care needs, a fact which appears to be reflected in the staffs' views on the role of AAC; indeed residents' communication as a whole is often described, rather narrowly, in terms of the expression of needs and wants.

Francine at Bungalow A was one of the few staff who said that Mary's book actually fulfilled this purpose. I asked what would happen if the book didn't exist?

It would be difficult for new staff to know what she wants. At the end of the day it's about what she wants, not about what we want to do for her.

Claire at Bungalow B did not know about the book; she said:

Claire: That's my aim, or the aim of the key worker, to give Mary access to whatever she wants. If she sees something, you know, like a PECS [Picture Exchange Communication System] *or a Widgit symbol, that she would like to do that.*
Steph: It would be a way for her to say what she wants?
Claire: If she doesn't actually see it, she can't ask for it. Which doesn't mean she wouldn't like to do it. If she seen it, she could gain access that way.

Sue commented about another resident's use of a communication book:

Steph: And would she use it to express things to you?
Sue: I never saw her actually pick it up to say 'I would like a cup of tea'. No I never actually saw her do that… she never actually got the book. You know, if she wanted a drink, she'd never go and get it and point to it. No.

It is noteworthy that Sue's interpretation of my question only encompasses expression of wants. In the case of aided AAC (e.g. a book or electronic aid as opposed to signing) the contents often exhibit a reliance on physical things which can be photographed or represented by graphic symbols. It may be that this bias acts to skew interpretations of its use towards requesting. However, selecting an item can have many pragmatic functions, such as: I like that usually, I had that earlier, I've changed my mind about that, Would you like it? and so on. In Mary's case, she does not have the means (or possibly the necessary linguistic or cognitive skill) to clarify what she might mean by pointing to a picture, and it seems that staff do not

tend to think beyond requesting as the probable intent behind a selection made from an AAC system.

AAC was also seen as a way of expressing a preference or choice in response to something offered, rather than initiated by the individual. I asked Francine at Bungalow A about Mary's book:

> *Steph: What do you think the book is for? Why do you think it was made?*
> *Francine: Since she can't communicate with us verbally, it is easier for her to tell us what she likes.*
> *Steph: Does the book have an important role in her communication?*
> *Francine: Yes. We don't choose for them. We might find out where she wants to go. Sometimes we run out of places to go so she would give you her choice.*
> *Steph: And she uses it in this way?*
> *Francine: Sometimes. Like on Sundays, she always goes to church so we don't need it then.*

In fact, neither my own observations, the views of most other staff members, nor Francine's own example support her view about Mary's book enabling her to express what she likes or wants.

Below is another instance in which staff suggest or claim that a resident is using AAC (Mary's use of a sign or gesture in this case) to express a preference. I asked:

> *Steph: If you ask her a direct question, does she say yes or no?*
> *Rula: it depends what you're asking her. Like if you said 'do you want a cup of tea?', she'll go 'tea'.*
> *Cheryl: or cake, she'll say 'cake' when you've said it. And if you say 'do you want to go on holiday?' she'll point to the sky.*
> *Steph: does that mean ['yes'?*

Cheryl: [plane.
Steph: 'cos she's not actually saying 'yes' or 'no' is she?
Cheryl: but if she didn't want to go she wouldn't point to the sky.

An alternative interpretation is that Mary is simply responding to the new topic of conversation, by supplying the sign to go with the word.

Sue suggested the possibility of beneficial effects of AAC for Hilary, regarding expression of feelings. I asked:

Steph: What would it do for her if, for example all the staff knew and used Makaton with her?
Sue: I think it would erm [pause] maybe if we did all use it, if we all knew it and we all used it, perhaps she might be calmer I think. Maybe because she'd be able to explain her needs better to us. If she could express more, yeah. I think she would be calmer. I think it's frustration probably. It may be her anger outbursts, her shouting outbursts, I think probably is a lot of frustration. She can't get it across to us, what she wants to say, or maybe we haven't got enough staff on to do what she wants to do.

Carl supported the above view; he told me:

When Hilary was crying…Hilary's vocabulary has run out and we haven't taught enough Makaton signs to help express further.

That AAC can be a way of requesting attention was an interpretation cited by several people to explain Hilary's extremely frequent pointing to her mouth. Her mother told me it meant 'drink', although she usually ignored it. Often, Hilary did not then get a drink for herself and nor did she show frustration when she was not given one. She would simply repeat the gesture. The home manager told me Hilary points to her mouth to request drink, food or attention. Beukelman and Mirenda

(1998) draw attention to the possibility of one message 'masquerading' (p8) as another, or fulfilling a different function from what it superficially appears to, and staff clearly showed insight into this. However, that Hilary's gesture did not tend to work to communicate any of the three possible meanings suggests that the sign was not being used with communicative intent or that it was not being interpreted as such, but that it was simply regarded as a habit.

2. Information exchange

While expression of needs and wants was the most commonly cited purpose for AAC, information transfer was rarely recognised by staff, according to my evidence. In common with research on interaction between older children with physical disability and motor speech disorder and their care givers (Pennington and McConachie 1999) genuine information exchange (in contrast to test questions) is a rarity in my study.

Mary's book, with its extensive and highly specific content, appears to have been created for the purpose of not only the expression of needs and wants but also to a lesser extent, information exchange. However, Mary's usual use of the book with staff does not suggest that it fulfils either of these functions. Her communicative intent is usually hard or impossible to discern, from the many pragmatic possibilities (see above). That Mary's book does not enable intent to be distinguished is typical of many AAC systems (Light et al. 1985b) in which vocabularies mainly cover propositional content.

A possible (but by no means certain) example of the exchange of information is in Excerpt 24 when Francine sits looking at the book with Mary. Much of the interaction is controlled and initiated by Francine (see also Excerpt 8 for the interaction preceding this excerpt); however at minute 1:37 she issues what appears to be a request for information: *Where do you like to go most?* Then at 2:09 Mary points to an item, an initiation which Francine interprets as *That's what you like. You like to go out, eh?* It is impossible to say whether Francine already knew the information Mary conveyed.

Excerpt 24
Setting: living room: researcher behind camera
Participants: resident Mary and staff Francine sat next to each other looking at communication book.

Time Secs	Mary : non-verbal	Mary: verbal/ vocal	Staff : non-verbal	Staff : verbal
1:36			Turns page to 'places' and re-orientates book	
1:37				Where do you like to go most
1:38	→ and ► item on page	(1)		
1:39				Ey?
1:40	→ and ► adjacent item			
1:41				(2)
1:42				
1:43				
1:44				
1:45				
1:46			→ and ► item in book: pub	You like to go to the pub?
1:47	→ and ► item in book: pub		→ Mary	
1:48				
1:49	→ Francine			Ey?
1:50				laughs
1:51	→ researcher	laughs	→ book	
1:52				
1:53				
1:54				
1:55				
1:56				
1:57	→ and ► item in book: pub			
1:58				
1:59				
2:00			→ and ► item indicated by M	
2:01				
2:02				
2:03	→ and ► adjacent item			
2:04				

2:05				
2:06	→ and ► another item			
2:07				
2:08			Turns page	
2:09	→ and ► item in book			
2:10			→ and ► item in book	Oh! laughs
2:11			→ Mary	
2:12			→ and ► item in book	
2:13				That's what you like
2:14				
2:15	→ researcher whilst still			
2:16	► item in book			You like to go out, eh?
2:17				
2:18				

Staff's views about residents' communication tended to be so narrow that, in discussion with Claire, I probed further regarding Mary's use of a communication book. Claire's response is not easy to classify according to Light's categorisation, but may suggest information exchange:

> *Stephanie: Would there be any other advantages than making choices or expressing an interest?*
> *Claire: Well, yeah, because, you know, people just presume what she likes and dislikes. It's not just likes and dislikes; she might not have been feeling very happy. She might be feeling ill. How would she tell us? Sometimes you go by behaviour.*

3. Social closeness

Staff at Bungalows A and B did not recognise that AAC might play a role in this function. Nevertheless, Mary's use of the book suggests that this was in fact one of its main benefits for her. This may be another example of the 'masquerade' (Beukelman and Mirenda 1998) that is possible in interaction. This concept of 'masquerading' parallels Fairclough's concept of the metaphorical relationship in which, for example, what appears to be a knowledge exchange actually functions as

a request for action (such as giving attention). When I sat with Mary and her book our interaction was much as it is when we looked at magazines together. Mary did not appear to use it to communicate something specific that she would not have been able to tell me without the book. Rather it enabled Mary to hold my attention in an enjoyable interaction.

At Hilary's home staff made a link between her communication and her behaviour, specifically the shortage of Makaton vocabulary in her repertoire, and the occurrence of challenging behaviour. While this does not fit very comfortably in 'social closeness' it nevertheless has implications for the development and maintenance of interpersonal relationships.

4. Social etiquette

Excerpt 25 was the only piece of data that demonstrated the use of AAC for the purposes of social etiquette; in it Michelle asks Hilary to use the Makaton sign *thank you*.

Excerpt 25
Setting: lounge; researcher is hand holding camera
Participants: resident Hilary sat down; staff member Michelle stood to the side.

Time: secs	Resident: non-verbal	Res't: verbal/ vocal	Staff: non-verbal	Staff: verbal
1.	Drinks from cup		Watches H drink	Hilary.
2.	Lowers cup; →M	(1)		Say 'thank you'
3.				Do it then, thank you
4.			Makaton sign *thank you*	
5.				
6.				
7.	Hand moves towards and away from face		→ researcher	
8.				Yeah, well done

Staff did not seem generally aware that social etiquette could be achieved through AAC, and the role of politeness conventions in the interaction between staff and residents is discussed in the previous chapter.

Other findings about AAC

From the data emerged other aspects of AAC, not necessarily to do with purposes of communication. For example, much of Mary's contact with the book was solitary i.e. not for interpersonal communication; the staff member Suzie in Bungalow B seemed to view it as being an enjoyable pastime. She told me:

> *Suzie: I haven't seen her look at it. But she may look at it when I'm not here. She tends to do her beads and her jigsaws; she's happy to do those.*
> *Steph: what purpose do you think the book might serve?*
> *Suzie: What, for Mary? [sounded perplexed] She might recognise the staff from the past… photos of places from the past. Where she used to live. They like to look back at photos of themselves.*
> *Steph: So you view it as like a photo album?*
> *Suzie: yes.*
> *Steph: I suspect that it was made with a different purpose in mind- to help Mary tell you things she doesn't have the words for.*
> *Suzie: She'll ask for tea. If she wants something to eat she'll point to her mouth. ..certain things she'll do. I don't really think it'll help her tell us what she wants; its' more like she would look through a magazine.*

Indeed, when Mary 'used' the book, it was indeed in very much the same way as she would browse through a magazine, even when in the company of others. In Excerpt 26 in which Mary and I look at her communication book together, Mary

points seventeen times in the first minute alone; I name each picture in turn, even when she returns to the same pictures again and again.

Excerpt 26
Setting: living room; I had requested and been given permission to look at Mary's communication book.
Participants: residents Mary and Claude and researcher S

Time Secs	Mary: non-verbal	Mary: verbal/ vocal	S: non-verbal	S: verbal	Claude: Non-verbal
1.			Opens and → book		
2.	► at item on page				
3.				A picture of Mary	
4.	Turns page				
5.					
6.				Oh, you're interested now are you	
7.					
8.	Turns page				
9.				'people'	
10.			Re-orientates book		
11.	► at item on page				
12.					
13.				A picture of Cheryl	
14.					
15.	► at another item on page				
16.				And Claude	
17.					→ Mary
18.	► at another item on page				→ TV
19.				Muriel	
20.			→ Mary then → book		
21.			► at item in book	I don't know Muriel	
22.	► at another item on page				
23.				I know Joy	
24.					
25.	► at item on page				
26.	► at item on page			Yeah, Joy	
27.				Maria	
28.	► at item on page				
29.	► at item on page			Joy	
30.				Gwen	
31.					
32.					
33.				Gwen's gone to bed hasn't she	
34.					
35.					
36.	► at item on page				
37.			► book; → Mary	Claude. What about Claude!	
38.					
39.		Claude			
40.	► at item on page		→ item in book		
41.				Joy	

42.	► at item on page				
43.				Gwen	
44.	► at item on page				
45.	► at item on page			Cheryl	
46.					
47.				Jerry!	
48.			► item in book		
49.			→ Mary then → book		
50.				Jerry's not here anymore is he	
51.	► at item on page				
52.				Gwen	
53.	► at item on page				
54.				Joy	
55.	► at item on page				
56.				Claude	
57.		Claude	→ Claude		
58.	→ and ► Claude			Yeah	
59.				Hi Claude	
60.	→ and ► book			We're looking at your photograph	→ S
61.					

The same phenomenon is illustrated in another style of transcription (based on one done contemporaneously) shown below. The labels of photographs that Mary pointed to (►) are in CAPITALS; other things or people physically present that she pointed to are in small case:

> Mary: ► GOING OUT, ► CHERYL, ► JOY, ► CHERYL, ► JOYCE, ► Gwen
> Steph: has Gwen got a picture?
> Mary: ► JOYCE, ► CHERYL. [flipped some pages] ► GOING OUT, ► GOING OUT, ► HOME, ► COMB, ► her own hair, ► GOING OUT, ► CHERYL, ► MARY, ► JOYCE, ► GWEN, ► CLAUDE, ► CHERYL, ► CHERYL, ► LENNY, ► fish and fish tank, ► CHERYL, ► MURIEL.

This type of interaction is typical of Mary and yet so untypical of communication in the wider world that I made the following observations in my field notes:

> *Out of the many pages in the book, Mary was returning time and again to the pictures that she had singled out most frequently when we looked at it almost three weeks previously. I think this is unlikely to be coincidence. It raises the question of whether she means anything specific when she points, and if so, what*

she means… But the underlying assumption still needs to be questioned: is she intentionally communicating in order to achieve a goal, or communicating for its own sake- a distinction made by Ware (2003) in her discussion of the stages through which intentional communication develops, in the context of people with profound and multiple learning difficulties.

The potential for AAC to be used by *both* participants in an interaction (for example to support the understanding of the less able individual) was only commented on by one staff member. Sue told me about Trisha:

> *Sue: She did get it [symbols book] out now and again. Not often.*
> *Steph: and it was useful now and again?*
> *Sue: It was, yes. If you was going out, you could explain better to her, rather than 'going on the minibus' it would be 'we're going on the bus'. Do you know what I mean? Like, to town, the number 2 bus, or something. Show her the different pictures.*

Both staff Cheryl and Francine were observed to use Mary's communication book to get her to demonstrate her skills; an example is Excerpt 7 in which Cheryl used a long string of test questions (for example: *Where's the hairdressers? Where do we go shopping?)* to which Mary responded by pointing to the book. (This is discussed more fully in the previous chapter under 'Test questions'.) This may also be what was happening below, when Mary had been pointing to things in the magazine and an interaction ensued. In reference to the car photograph, Cheryl said:

> *Whose is it? Is it yours? Is it Jo's? Are we going on holiday? What are we going on?*

I had witnessed an exchange on this theme before; it seemed to be a rehearsed routine, used to prompt or encourage Mary to demonstrate her sign for *plane*.

On occasion, staff also demonstrated their knowledge of AAC, possibly to provide models for learning. This may have been what was happening in Excerpt 20, in which Michelle accompanies her spoken *Thank you* with the Makaton sign (at second 8). Similarly Claire did so with Mary:

> *Where are you going? To church? This?* [puts hands in praying position] *Lovely isn't it. Where else do you go? Do you have a walk?* [gestures walking with fingers].

Recommendations and Experiences of AAC

As a speech and language therapist with a professional background in AAC, I was struck (but not surprised) by discrepancies between my own conceptions of AAC and those of the staff. In this section, I explore such discrepancies that arose in the data, particularly as described by staff. For example, when I asked the new manager of Bungalow B about Mary's book, she said she knew nothing of it but suggested *We could try it with her.* Since Mary can get the book, turn the pages and indicate items all independently (i.e. she has considerable linguistic and operational competence (Light 1989), see Chapter 2: Literature Review), it was not clear to me what would actually be being tried.

At Long Lane there was direct opposition between staff views and professional recommendations; this was graphically illustrated in one resident's file where SLT guidelines said:

> "OBJECTS OF REFERENCE AND MAKATON SIGNS SHOULD BE USED CONSISTENTLY AT EVERY APPROPRIATE OPPORTUNITY

BY EVERYBODY!...OBJECTS OF REFERENCE AND MAKATON SIGNS ARE FOR PERMANENT USE AND ARE NOT SHORT TERM!"

When asked, staff said Objects of Reference was tried as *an experiment.* In neither of the above examples was there any apparent expectation of the AAC system being an ongoing method of communication.

Mick at Number 32 did not have a very positive attitude towards Makaton, nor towards professionals making recommendations:

> *They come in and tell us we've got to give choices but they don't know the clients. Certain things I do agree with; certain clients can understand.*

He continued, about Makaton:

> *In my experience, it's no good. They've never done it before; they just go along with it. They don't know what you're on about. They've done the same things for years and years and years, in institutions. You can teach them to point or teach them a sign, but they don't know what it means. It's never ever worked. Anyone can point to picture cards. It's giving them a choice but it doesn't necessarily mean they want it.*

At Long Lane, one staff member expressed similar resentment that recommendations are unrealistic. He told me:

> *Someone said Rob used to use Makaton. Sometimes it does seem like he's signing but we don't know what it means and we don't know if* ***he*** *knows what it means. He could just be copying from someone. But we don't know. I can't see any of the others learning Makaton or sign language. Maybe they would understand it but I don't think they would actually use it.*

Mick did not have a high opinion about the usefulness of AAC. He told me:

Trisha next door uses a bit of Makaton …she will point to her lips as soon as you walk in, to ask for a drink. But she might have just had one; she constantly wants a drink but they have to limit the amount she has.

The lack of need to use AAC (or even communicate at all) has long been recognised by SLTs and researchers. For example, Light et al. (1985b) suggest that intervention should be directed towards providing children who use AAC not only with the skills but also the opportunities to use a wide variety of pragmatic functions.

AAC was rarely experienced by staff as genuinely useful. Indeed I experienced this myself: I had been sat with Mary as she browsed through her book one day. My field notes record:

Then she looked at me and said 'tea' but I wasn't sure at first. She repeated it, looking at me intently and maintaining eye contact, leaning forward. It was different to most of her vocalisations, which are as if she is just maintaining someone's attention. Her manner made me realise she was indeed asking for tea. Ironically, I later noticed that 'tea' was in her communication book. Our joint attention had shifted away from the book during this exchange.

At Bungalow A, Cheryl and I discussed Mary's communication:

Stephanie: So Mary's only got a few spoken words. Has she got other ways of expressing herself?
Cheryl: She'll point to things in the book.
Stephanie: I've not seen her do that.
Cheryl: If you've got the Argos book, she always points at a bed.
Stephanie: in the Argos book? Sorry I thought you meant the communication book.
Cheryl: She's actually got a book with pictures in it.
Stephanie: yes I've seen that, but I've never seen her use it.

Cheryl: No she don't tend to use it.
Stephanie: does she look at it?
Cheryl: With Mary, 'cos we've worked with her so long, if she wants some'at we've got our own way of communicating really. We know.
Stephanie: how do you know?
Cheryl: I don't know; we just know. We just know, don't we?

This member of staff was not alone in claiming considerable expertise in the interpretation of a resident's messages; success in communication is often believed by staff to be reliant on their own skills, not those of the resident. Reliance on non-linguistic natural methods of communication is also characteristic of interaction involving many non-speaking children (Pennington and McConachie 1999). This was echoed by another staff member after Mary had moved to Bungalow B:

Stephanie: you don't think the book would help Mary communicate?
Suzie: I'm not really sure. I don't know her very well; she hasn't been here long.
Stephanie: Is it because you feel she communicates effectively already?
Suzie: yes I think so.
Stephanie: You don't get the feeling she has lots more to say that she can't express?
Suzie: no not really.

Comparisons with the AAC literature

Broadly speaking, my data about AAC use generated few surprises, given the findings of published research. In summary, the data indicate some, but limited experience and awareness amongst the staff, of both AAC generally and specifically

relating to individual residents. Use of AAC and opinions about it were often at odds with those recommended and held by professionals. This is likely to contribute to what Beukelman and Mirenda (1998) and others describe as 'opportunity barriers' to AAC use. These barriers limit communication but originate in others in the environment, not the would-be AAC user (Beukelman and Mirenda 1998). It is widely recognised that intervention procedures for the maintenance of AAC skills must address the issue of communication opportunities e.g. Binger and Light's training programme (1998).

Similarly, Calculator (1988), some ten years previous to Beukelman and Mirenda, discussed the various sorts of pre-empting in natural environments which can result in lack of use and subsequent loss of communication skills. Lack of motivation and reason to communicate and lack of responsive partners are suggested as reasons for lack of AAC use (Calculator 1988). Of the four residents, I believe that only Mary and Hilary had such little speech as to result in relatively strong motivation to use AAC; I cannot comment on any loss of skills because I had no way of studying their skills during earlier periods of their lives. However, I did see evidence of the pre-empting mentioned by Calculator: residents had little need to ask for drinks, as the staff member Sue said: *I think it becomes a way of life. You are constantly making drinks. And everybody has drinks.* Perhaps surprisingly, Hilary, Sarah and Mary would nevertheless ask for drinks, but often did not have their requests fulfilled.

Regarding Calculator's point about lack of responsiveness, my data do not make a strong case for this for the individuals in my study. Residents did initiate communication and staff did respond, and much of the discussion so far has been to

do with the nature of this interaction, not the absence of it. Nevertheless, 'amount of interaction' was a code which emerged from the data early on, and was usually used to refer to instances of lack of interaction. The aim of my research was not to explore the lack of interaction per se, and this was not a code I selected for detailed analysis – but it could have been.

My data appear to concur with that of Pennington and McConachie who remarked about the school aged children in their study: "given the restrictions that seem to be imposed on children's interaction by their partners and the infrequent need to express novel or abstract ideas, which would necessitate the use of a formal linguistic code, limited use of aided communication systems is not unexpected" (Pennington and McConachie 1999, p395). Similarly, the residents do not need to use AAC as long as interaction with staff stays pretty much the same. Pennington et al also observed the tendency in these children for early patterns to persist rather than evolve: in contrast, non-disabled children's interaction with adults rapidly becomes more equal and demonstrates a broader range of functions.

This situation of AAC having little or no presence in the homes is not surprising, partly because the research sites were selected on the basis of an absence of AAC; neither is it likely to be unusual. Light, Collier and Parnes (1985c), in their study of non-speaking children with functional AAC systems found (and Pennington and McConachie's later study (1999) confirmed this) that over 80% of communicative turns were achieved by non- communication board methods (vocalisation, gesture, eye gaze). According to Bradshaw's (2001) review of the literature, the lack of AAC use is also true of adults with learning disabilities.

The nature of the environments that adults with learning disabilities often find themselves in is of relevance to their communication. According to van der Gaag (1989) "the expectations of non-handicapped individuals can have an important influence on the communication skills that the handicapped person actually uses" (p222). She found that adults with learning disabilities in community settings (as opposed to hospital environments) tended to have better pragmatic competence than would be predicted by their linguistic competence, which was the same for both groups. Basil (1992), in her research on children with severe motor disabilities found that provision of AAC (communication boards) did not on its own change interactive styles of the (dominant) speaking partner, or therefore of the style of the dialogue in general, in which both the children and adults were largely unresponsive to each other. Change in behaviour of adults, following a training programme in which communication partners were taught to be more responsive, was needed to change the pattern of AAC use.

The literature within the AAC field reports repeatedly on patterns of AAC use and non-use amongst various populations. However, it stops short of offering explanations beyond the level of individuals and their immediate environments, and does not make explicit the links with the concept of power. At the time Light published her paper on the four purposes of communication (1988), the field of AAC had given most attention to the expression of needs and wants, a bias that appears to be reflected in the perceptions of staff. This failure to promote other functions of communication within an AAC system, has the effect of constraining communication into brief and predictable exchanges, rather than the lengthy ones required for exchanging new and interesting information or for developing

interpersonal relationships. However, what the literature does not appear to suggest is that using AAC only to express needs and wants maintains the user in a less powerful position, since it is the naturally speaking partner who has the power to grant or deny those needs and wants. Therefore, AAC may be useful only in ways which tend to reinforce existing power relations between participants. Similarly, to exclude politeness conventions from an AAC system denies the user the opportunity to practise social etiquette as an equal with speaking communication partners. In the following section I look to the literature on power to provide a perspective on AAC.

AAC and power

According to Fairclough (1989) discourse analysis involves not only description of texts, at the level of the immediate environment, but also processes of interpretation and explanation, at the level of the institution and of society as a whole. So far, I have concentrated on text analysis, with references being made to the second level, care home practice as an institution. In this section, my aim is to develop interpretations and explanations further, thereby making links with the points made about service provision for people with disabilities and their place in society in Chapter 2: Literature Review. A fundamental assumption of CDA is that discourse and power are in a dialectical relationship: "As well as being determined by social structures, discourse has effects upon social structures and contributes to the achievement of social continuity or social change" (Fairclough 1989, p37). The question of whether the introduction of AAC may contribute to continuity or change

is explored further in the next and final chapter, but in this section I explore the role of AAC in this dialectical relationship referred to by Fairclough. I start by considering the 'top-down' direction of influence: how power relations within society may affect discourse involving AAC.

Power relations may influence every level of AAC implementation, from its introduction, customisation for the user and its subsequent functioning within interaction. Some evidence was cited above to suggest that rejection of AAC in the first place could be accounted for by the perceived lack of need for AAC, due to staff claiming considerable expertise in the interpretation of residents' behaviours.

At the next level, if AAC is accepted, how it is set up (for example, in terms of vocabulary) will also be influenced by power. Many potential AAC users with learning disabilities (including Ralph, the participant in Brewster (2003), who used both high- and low-tech AAC systems, and the four residents in the current study) are likely to need pre-stored vocabulary sets since spelling or other selection methods for creating novel messages is beyond their abilities. The inclusion of appropriate vocabulary can enable communication about topics beyond the here and now, and hence impart more interactional control to the user. For this reason Beukelman et al. (1991) suggest various vocabulary selection techniques to promote interaction beyond requesting. Others are inevitably involved in vocabulary selection, and this process will be imbued with power relations (Brewster 2003). This paper presented evidence of this, from interviews with Ralph's carers; they had made an observation about the tone of voice in which a message was recorded on his device not always suiting either Ralph's personality generally or the intent of his

utterance on that particular occasion. I explored this with them regarding the vocabulary included on his device:

> *Steph: what if […] Ralph wasn't a very likeable person and went around swearing all the time? Would you put swear words on his communication system if that was the kind of person he was?*
> *Carer A: I suppose you'd have to.*
> *Carer B: yeah you would. If that's the way they feel and that's what they want to say that's fine.*
> *Steph: so in theory you wouldn't have a problem with putting loads of swear words into a communication system?*
> *Carer B: you wouldn't say the F word; you would say them in the nicest possible way.*

Evidently, Ralph is not permitted full access to certain types of discourse which would usually be fully accessible to people of his age, gender and cultural background. It appeared that staff did not find it acceptable for Ralph to use his communication aid to express feelings that they might find unpalatable. Whether natural or aided methods of communication are used, in both instances the listener needs to accord the individual the 'right to speech' (Bourdieu 1977) i.e. to believe, obey, and respect them. But Ralph may not hold sufficient 'authority' to command this from all listeners. Ralph is likely to be disadvantaged, as are people with disabilities generally, in terms of the 'symbolic power relation' between himself and non-disabled others. Even in the relatively sympathetic environment of this home, his power to command the listener may not be fully established. Ralph's limited access to the community's verbal repertoire means that he has little scope to vary the style of his language in order to underline his own authority. The exclusion of

residents from discourses, discussed in the previous chapter, appears unlikely to be eliminated by AAC.

According to Bourdieu it is not only the discourses a person is able to produce which result in a certain type of reception, but the combination of all forms of capital; "speech always owes a major part of its value to the value of the person who utters it" (1977 p652). In Bourdieu's terms, the residents may not always have the power to impose reception; rather it is conditional on what they say being considered appropriate by those in positions of power. In Ralph's case, swearing in certain ways would seem to break the rules of acceptability which govern what is sayable, and by whom, in this context (Bourdieu 1977). It appears that some staff may want to empower the residents to say whatever they want only as long as it is said *in the nicest possible way*.

While Bourdieu's argument has been applied to Ralph's use of AAC, it has considerably wider relevance. For instance, Claude's offers of help and evaluative comments (see p136) regarding the behaviour of other residents have no authority with the staff. Another example that illustrates this point is an occasion when Sarah had been persistently asking to be moved to another chair; help was not forthcoming. She then starting asking to go to the toilet, eventually declaring herself to be wet. The home manager Meera interpreted this as *clever*, as if she viewed it as a strategy for manipulating staff into giving her what she really wanted. Staff prioritised physical care needs (such as promptly changing a resident who is wet so that their skin does not become sore) over a resident's preferences about where they sit, requests for which were apparently not considered appropriate by staff. The

power relations between staff and residents illustrated by this incident are further underlined by Meera's evaluative comment about Sarah, not about the staff who had not responded to her requests.

In terms of interaction, it may be that power relations have even greater influence over discourse when communicative competence is highly asymmetrical, since difficulties of interpretation are common. Whether an individual uses AAC or not there is a relative absence of contextualization cues (Gumperz 1999). These are defined as "any verbal sign which when processed in co-occurrence with symbolic grammatical and lexical signs serves to construct the contextual ground for situated interpretation, and thereby affects how constituent messages are understood" (Gumperz 1999, p461). Examples include code switching, prosody and rhythm; these are ever present in talk but not in the communication of those with little or no speech. The failure of communicative intent to be encoded into AAC systems is a tendency that was pointed out above. Even interaction with an individual able to communicate with AAC in a very sophisticated way (e.g. Alex – see Chapter 3: Methodology and Appendix 10) often leaves one unsettlingly unclear as to the real intent of a message. If context is imbued with power relations then interpretation will be influenced accordingly. For example, if a resident is viewed as dependent and needy, their communication, if ambiguous, will be responded to as requests or needs rather than transfer of information. This does indeed appear to be the case amongst staff in this study, who emphasise the 'expression of needs and wants' in residents' communication, almost to the exclusion of other functions.

As pointed out above, the relationship between power and discourse is bidirectional; I now go on to suggest some of the ways in which discourse involving AAC may or may not affect power relations from the bottom up. I start by going back to the response of staff to Ralph's use of his communication aid (Brewster 2003). Discussion with carers about the vocabulary in Ralph's AAC systems indicated that when there was a lack of congruence between modalities, staff looked to Ralph's natural modes of communication to find out what he was feeling, rather than to the message he selected. Carer B commented on one of the vocabulary items on his device, *I'm going to sort you out*:

> *Carer B: That's when someone offends him, and Ralph's way is 'No way', 'I'm angry'. But he doesn't mean it.*
> *Steph: I'd assumed that was meant in a jokey kind of way.*
> *Carer B: yes, it was. It's in a jokey way but he doesn't mean it. It just means 'you've upset me', 'you've offended me'.*
> *Steph: if he really did mean it, if he really had been offended, would you know?*
> *Carer A: yeah, Ralph would come and tell us.*
> *Carer B: you can see.*
> *Steph: but he wouldn't necessarily use that [the communication aid]?*
> *Carer A: no.*
> *Carer A: I don't think he would even use that if he was really angry. He uses that more as a jokey playful thing to be honest. And I think if he was really angry, it's more you can tell, can't you, with Ralph. Ralph's very expressional with his face…*

As with Ralph's carers, it appeared from interviews with staff in the current study that they too did not see AAC as having a substantial role in the expression of feelings, a purpose of communication involved in social closeness (Light 1988). It is quite possible that this could act as a disincentive to the use of AAC for such

individuals although I do not have data to support this. Nevertheless, these examples may be indicative of the lack of influence at a discoursal level, of AAC on the power relations between residents and staff, and maybe more widely between people with and those without disabilities in society.

Many applications of CDA involve interaction in fairly formal institutional settings such as between doctors and patients, or pupils and teachers, where asymmetries in power are relatively transparent. Can relationships between residents and staff be compared to those between professionals and public in other institutional settings? These homes are characterised by a high degree of interpersonal informality, and interpersonal relationships are encouraged i.e. professional distance is not maintained. Everyone is on first name terms; residents had met the families of several staff and had visited their homes. Physical contact may be connected with care tasks or may be of an affectionate nature, for its own sake. It appears that staff are under the same contradictory pressures identified by Fairclough (1989) as in other institutions: to act professionally (e.g. to maintain standards of safety and care), but also to treat residents as individuals. However, interaction in the settings I investigated may be subject to less stringent constraints than in more formal institutional interaction, and therefore in theory, power may be more open to challenge.

Diamond (1996) says that power is consensual and open to negotiation through discourse; that power is accessible to all, on a micro-level, through communicative competence and creativity. Unfortunately these two attributes are relatively unavailable to the residents, and so they are not in a strong position to reject the

roles assigned to them, or to challenge the power claimed by (in Diamond's terms) those of high institutional rank: the staff. While my data lend some support to Diamond's claim that power is "in a state of dynamic flux" (p115), my evidence also suggests that discourse is most often tipped in favour of staff. Diamond explains that power is exerted through discourse in ways such as: successfully taking the floor, holding it for long periods, being listened to, agreed with, having suggestions followed. Although at a superficial level residents are often successful in these ways, their success comes through concessions made by staff and so do not represent serious challenges to the status and authority of staff. It is possible that AAC may enhance certain competencies of the residents, such as a wider choice of topics that can be introduced, but it may not enhance others, such as the likelihood of being listened to and having suggestions followed.

In this section I have made a case for AAC not necessarily having sufficient influence to redress asymmetries of power between residents and staff, even if it enhances the communicative competence of residents. Indeed, use of AAC in interaction with a naturally speaking partner is hardly symmetrical, and in some respects could be less so than if only natural or unaided methods of communication are used. For example, a communication book requires the partner to watch the book, not the user; this interrupts eye-contact which normally enables the fine tuning of the interaction, for example by regulating turn-taking (Arvidson et al. 1999). High-tech devices which provide voice output differ in this respect, but nevertheless retain potential asymmetries when used in interaction with naturally speaking partners. Constraints on the amount and nature of vocabulary included in the system (whether high or low tech) has already been discussed. It is also likely

that the severity of the learning disabilities experienced by the residents may mean that their communication would always be less sophisticated than that of the staff.

In the next chapter, I summarise the findings of Chapters 5 and 6 in terms of the themes turn taking, topic control, exclusion from conversation, activity exchanges, politeness, test questions and AAC. I also develop further the discussion of the potential for AAC to alter asymmetries in the interaction between residents and staff.

CHAPTER 7: DISCUSSION

Introduction

This final chapter draws some conclusions from the findings of the investigation. I compare these to the aims of the research, laid out in the first chapter, and review the extent to which the aims have been achieved. I go on to assess how the investigation contributes to our knowledge in the field, and what further research is indicated. A critical evaluation of both the thesis and of Critical Discourse Analysis (CDA) then follows. I start by summarising the findings, according to each theme.

Summary of findings

In Chapters 5 and 6 transcriptions of interaction between staff and residents were scrutinised from the perspective of CDA, drawing particularly on the work of Norman Fairclough. Several themes were selected for their salience regarding the power relations between the two groups of participants. The themes of turn taking and topic control constitute interactional control features (Fairclough 1992b) which ensure the smooth running of interaction. One of the products of such features was the phenomenon of exclusion of residents from conversation- the third theme. Analysis also centred around the concept of the activity exchange (Fairclough 2003), with particular consideration given to the ways in which staff and residents got each other to do things through interaction, the fourth and fifth themes.

Politeness, conventions of which are commonly used in such exchanges, was the sixth theme. The phenomenon of the test question (seventh theme) was treated as a common feature of the activity exchange. The final theme, AAC, has no presence in the CDA literature; therefore a less structured approach was used to bring a critical perspective to the data pertaining to AAC. The next section summarises each theme.

Theme 1: Turn taking

The data demonstrate that all residents are able to recognise when it is their turn to 'speak' (i.e. contribute either verbally or non-verbally), and do so much of the time, even when fulfilling this obligation results in only a minimal response. Staff use strategies to encourage and support a resident's taking of turns e.g. by structuring the interaction so as to increase the likelihood of the resident being able to make contributions. Residents also initiate interaction and allocate speakership to others. The theme of asymmetry in interaction has recurred throughout the data; paradoxically, there may well be ways in which AAC may add to existing asymmetry. The speed of interaction using an aid can be very much slower than speech or unaided methods of AAC (signing). If one participant in an interaction uses a communication aid and the other does not, aspects of that interaction such as turn taking may be more unequal than if aided AAC is not used (von Tetzchner et al. 1996).

Theme 2: Topic control

All residents demonstrate the ability to introduce topics and accept or reject topics introduced by others, although this may give a misleading impression of power being held by the resident. The more able communication partner has to bear

responsibility for the elaboration of topics and providing most of the content. Rapid shifting of topics was frequently demonstrated by Sarah, Claude and Mary. Although this could be seen as a competitive rather than collaborative style of interaction, it is perhaps more likely a reflection of their difficulties in maintaining interaction; others often make concessions to it probably because of this asymmetry in communicative competence. Furthermore, those residents with very little speech (Hilary and Mary) are only able to introduce topics if they have a referent in the immediate environment. In this regard, AAC could be seen as having the potential to transform the interaction of those individuals.

Theme 3: Exclusion from conversation

Residents are frequently excluded from the conversation of staff both by default (when interaction is too rapid or complex to permit participation from residents) and by virtue of certain discourses not being socially accessible to residents. The data offer numerous examples of staff talking about a resident in their presence. Rapid shifts between intended addressees within an interactional turn were common and residents seemed surprisingly capable of picking up on the often subtle cues (such as tone of voice) indicating this. Findings supported those of a previous research project (Brewster 2003) in which it was found that staff found it unacceptable for residents to use certain discourses (e.g. involving use of expletives) that would usually be available to individuals without disabilities. As well as the social conditions governing participation in discourse (Bourdieu 1977), in this situation there are very real linguistic limitations on the involvement of residents in interaction. Although staff exhibited some awareness of the need but also the difficulties of talking about residents in their presence, they also seemed insensitive

to the potential tactlessness of certain utterances. Residents exhibited both acceptance of, and occasionally resistance to, being excluded from conversation.

Themes 4 and 5: Activity exchanges

A high proportion of interaction was aimed at both staff and residents getting others to do things. The directive nature of much staff interaction is unsurprising and concurs with the published literature (e.g. Purcell et al. 2000). This may sometimes be because they require the residents' compliance in order to carry out care tasks. Staff were also directive regarding interaction itself (e.g. using test questions, see below). Residents too, issued directives; several residents in my research were highly dependent, so could be expected to frequently ask staff for help. The grammatical mood (Fairclough 2003) of these activity exchanges fell at various points along a continuum of intensity (Saville-Troike 2003) from demands, to requests and other less direct forms. Perhaps surprisingly, given Saville-Troike's proposition that in a relationship of asymmetrical power the relatively powerless participant uses less intense linguistic forms, both staff and residents (with speech) were found to use explicit demands. There are two possible interpretations for this finding. Firstly, staff may not consistently hold a position of power over residents within interaction; this would support Diamond's suggestion that power is "in a state of dynamic flux" (Diamond 1996, p115); hence there is always a risk of conflict between participants within discourse. Such conflict may be evident in phenomena such as staff members' occasional insistence on the residents' use of politeness terms when making requests. A second interpretation is that even those residents with speech may lack the communicative competence to mitigate (Ng and

Bradac 1993) requests and directives in ways that correlate with prevailing power relations.

Theme 6: Politeness

This concept was examined only with respect to the use of the politeness terms *please* and *thank you.* Politeness is ambiguous and serves different purposes in different situations (Ng and Bradac 1993). While politeness used by residents may be a sign of their relative powerless status, its use by staff may act as a device for disguising the power they have, a strategy of 'depoliticisation' (Ng and Bradac 1993, p92). Staff not uncommonly demand the use of politeness conventions from those residents able to do so, in much the same way that adults do of children (asking *what is the magic word*? for instance). This is a very overt sign of power. Staff exercised discretion however, and often waived residents' adherence to these conventions. Additionally, because of the different levels of communicative competence between residents and staff, a pedagogical dimension was also apparent: staff appeared to wish to teach residents about politeness conventions; while reflecting power, this paradoxically may have been aimed at equalising interaction. Politeness and 'social etiquette' (Light 1988) more generally were not perceived by staff as of relevance to AAC use.

Theme 7: Test questions

These were found to be a widespread feature used by staff within activity exchanges. The prevalence of the use of test questions by staff to residents was not surprising given that this is a widely acknowledged feature of interaction in which communicative competence is asymmetrical (Ochs Keenan et al. 1983). The data

suggest that test questions appear to fulfil a variety of functions, and are not just used by the staff member to control the interaction for control's sake. Rather, staff often use them to facilitate interaction with the resident on terms with which they can cope. Nevertheless, such questions constrain the immediate interaction, in terms of content, duration and pragmatic function of the residents' contributions. Lack of AAC use may in part be symptomatic of such constraints.

Theme 8: AAC

None of the residents made significant functional use of AAC. Hilary and Mary and some of their staff were seen to use a few Makaton signs, the interpretations of which may have been somewhat idiosyncratic. Mary alone had a communication book; it was not observed to be used functionally. It was precisely this latter situation that prompted my research interest: the abandonment and non-use of aided AAC. Much of the residential homes' documentation acknowledged the importance of effective communication and of AAC use, but this was not reflected in practice. Staff awareness of AAC was highly variable but generally limited, and often based on very narrow conceptions of what communication needs a resident might have and what role AAC might have for them. The traditional conception of language as a neutral vehicle for the conveyance of information, especially needs and wants, seemed to predominate, an emphasis that reflects AAC provision generally (Light 1988). The prominence given to this function of communication will tend to maintain the power relations between the two groups, since staff have the power to grant or refuse these needs and wants. A few staff recognised the need to use signs themselves if the residents were to use them, but this idea of reciprocal use did not tend to be extended to aided AAC. Often AAC seemed to be considered by staff as

yet another aspect of their job subject to external professional scrutiny which did not acknowledge their superior knowledge of the residents as individuals. Staff seemed to have little experience of AAC having been of genuine value.

In summary, I have concluded that any assumptions of residents' communicative incompetence and powerlessness in interaction are not straightforwardly upheld by the data. The concept of functional communication according to Light (1989) refers to the skills needed "to initiate and maintain daily interactions within the natural environment" (Light 1989, p138). By this definition, it appears that all four residents are indeed able to communicate functionally, without the use of AAC. However, a proviso is necessary: the 'natural environment' of the residents is carefully controlled by staff and makes few demands on the communication skills of the residents.

Staff seemed adept at using a variety of control features used to constrain interaction for a variety of purposes: they do so in order to facilitate residents' participation in interaction, for pedagogic purposes, and maybe also to control for control's sake. While contributions of the residents may be promoted in the short term (i.e. immediate interaction), long term this situation may result in a failure to develop interactive skills, and is likely to contribute to a reliance on natural methods of communication such that AAC use is unlikely to be either needed or sustained.

However, as indicated above, staff do not always hold power. Control of discourse conventions confers a powerful mechanism of domination (Fairclough 1992a). Powerful participants are able to determine which discourse types can be drawn

upon and hence which constraints act on subsequent discourse; these constraints also apply to powerful participants. The data demonstrate that it is not always the staff member who possesses this status; for example, Sarah appears to initiate a series of test questions by naming the piece of fruit she is shown (see p165):

Lisa; look!
Sarah; 'nanas.
Lisa; well done

Nevertheless, this may be an exception which proves the rule. In general, residents are so restricted in their ability to participate in particular discourses that they are rarely able to select a discourse for them and their partner to follow.

According to Fairclough (1992a) professional-client interactions in general (such as between doctor and patient) are becoming less formal and more conversational. Such styles of interaction enable the exercise of power to become less explicit, such that power relations are increasingly being maintained by consent rather than by force (Fairclough 1992a). This happens through the social practices set up, in which power is exercised through language. I found that interaction between residents and staff (who could be regarded as having a professional-client relationship) were characterised by a high degree of informality. I would not claim, however, that it resembles conversation between equals. Rather, some features are shared with other discourses in which there is a strong power differential between participants, for example between adults and children.

Such interaction is also asymmetrical in terms of communicative competence. For example, regarding adult-child interaction, Corsaro (1979) found that adults provide

structure to the interaction not for reasons of social control for the sake of it, but in order to negotiate shared meaning. However, despite similarities, the situation of interaction involving adults with severe learning disabilities is different. With children there is an expectation of interaction patterns changing as the child's skills develop. For the participants in this study, there may not be the possibility of such development, or more importantly there may not be such an expectation held by the staff who are interacting with them day to day.

The purpose of the investigation, however, was to go further, and explore the relevance of such findings to AAC use and non-use. I now go on to examine the extent to which the aims of the study were achieved, and the contribution this investigation may make to this body of knowledge.

Reviewing the aims of the research

In Chapter 1: Introduction I gave an account of the emergence of the aims of the project. They were, firstly:

- **To critically analyse the interaction between residents and staff in terms of power relations.** Critical Discourse Analysis (CDA) was used in the fulfilment of this aim.

And secondly:

- **To explore the hypothesis that power relations contribute to the lack of AAC use.** This second aim raises the question of whether the situation of

AAC non-use can be altered through an understanding brought about by such an approach; I reflect on this later in this chapter.

I feel confident that there are aspects of CDA that can be meaningfully applied to interaction involving non-speaking participants, and think it likely that the approach is equally applicable to interaction involving individuals using AAC. The unusual nature of such interaction means that considerable selectivity of analytic tools is necessary, if conclusions are to be drawn. Nevertheless there are numerous commonalities with more common forms of interaction, for example between cognitively able natural speakers, suggesting there may be further scope in such an approach.

Although there are examples of research which takes a discourse approach to the field of learning disabilities, an explicitly critical stance does not have a strong presence in the literature, in terms of its application to texts arising from people with learning disabilities themselves i.e. their own speech (Scior 2003). This investigation offers unique insight into the possibilities of applying CDA not only to the natural (unelicited) interaction of people with learning disabilities, but to that of individuals with severe learning disabilities who may communicate predominantly through non-speech modes. As such, this aim was ambitious, and conclusions are therefore tentative.

Regarding the second aim, although a personal wish to discover causes for AAC non-use offered the initial motivation for this project, it proved over-ambitious. Interaction is complex and AAC non-use is a multi-faceted phenomenon. It is clear

that power relations and interaction are closely intertwined, and there is no reason to suppose that this is not also the case where AAC might be involved. However, the nature and direction of causal links between power and AAC non-use still remain unclear, although it is likely that, as in interaction generally there is a mutual relationship between discourse and societal relations of power. All four residents were in middle or early old age, which may serve to remind us that individual styles of interaction should be seen within the whole life span (and indeed the same point can be made regarding the staff); a lifetime of communicating in ways that do not incorporate AAC are unlikely to be altered readily.

The highly individual character of both the participants and their interaction evident within this study indicates that a similar analytical approach needs to be applied to a great many more examples of interactional data, if conclusions are to be confidently drawn. It may also be the case (as Calculator (1988) enquired) that there are no "generic styles of interaction which can be shown to be facilitative when interacting with a particular type of individual, when using a particular type of AAC system, for a particular purpose" (Calculator 1988, p102). Further critique of this project and of CDA more widely is offered below.

Limitations of the research

The research project has been a learning process of huge proportions for me, and the writing of the thesis has elicited copious hindsight. One area in particular on which I have reflected is that of an emancipatory ethos, discussed in Chapter 2: Literature

Review. I did not set out to do emancipatory research, and do not claim to have done so. However, part of my learning as a researcher has involved an increasing awareness of the political dimension of research. I am disturbed by the bias towards involving only the most able and articulate people labelled as having learning difficulty, within research, and by how rarely this bias is made explicit. It is ironic that the ethical obligation to 'give a voice' to those who rarely get heard, which is so fundamental to this paradigm of research, is so infrequently extended to those least able to express themselves (Brewster 2004b). But we also need to be honest about the feasibility of people with severe learning disabilities participating in, or controlling their own research. Like Clegg, "I struggle to understand why anyone imagines they could obtain informed consent to, say, research participation from a multiply disabled adult with a developmental age of 3 months" (Clegg 2003, p4). While there may be some methodological progress yet to be made, we may need to accept that it may never be possible to entirely hand over the research reins. A number of limitations, both to do with the conduct of this project specifically and to do with CDA as an approach, are evident, and I turn to these next.

One limitation was associated with the inevitable compromise to be made between breadth and depth. Data collection was conducted at five homes in all; while this may strengthen the case for some generalisation of conclusions, it resulted in field relationships of insufficient depth for participation in the project to have any transformatory effect. I had initially hoped for participation to facilitate the personal development of staff in terms of their interaction with residents. But I had underestimated how difficult this might be to achieve. It requires that they give up what is familiar, and challenges their sense of meaning and direction (Schratz and

Walker 1995). However, familiarity with the five homes enables me to recognise the considerable commonalities that exist between them at the discoursal level of the institution (Fairclough 2001). Furthermore, my data largely concurred with previous research findings regarding interaction in such settings. At an individual level, residents and staff are hugely heterogeneous. It may be that more rigorous selection of participants with access to, but not using, AAC, as well as being more efficient, could have resulted in more focussed data collection. As it was, only Mary fitted this criterion. Nevertheless, the inclusion of residents who were able to speak was beneficial since it provided more scope for the application of CDA; it also provided some context for data derived from residents with very little speech, resident in the same homes.

One consequence of the data collection being so extensive (and of the analytical processes emerging relatively late in the project) was that in-depth analysis of data was not carried out simultaneously with its collection, so by the time findings were emerging, field work had been discontinued; it was therefore not possible to discuss these perspectives with participants. However, it may be that had both processes occurred in parallel the benefits of this may still have been limited. As Fairclough (1989) discusses, people are generally unaware of their participation in the legitimization or delegitimization of power relations through discourse. If this is the case, further discussion with staff is unlikely to have made a significant difference.

There were numerous strands of inquiry that could have been pursued, but which were not. Data codes which may have yielded relevant insight but which I did not

analyse in depth included: *pedagogic, scaffolding, control, tell Steph, correcting* and *discipline*. These could legitimately contribute to further research with similar aims.

Feedback to participants

In Chapter 3: Methodology, it was acknowledged that to conduct research in an emancipatory way, feedback of research outcomes to participants is a requirement. Disappointingly, this did not happen for three reasons. Firstly, the nature of my findings (new perspectives which draw on areas of theory not previously applied to this sort of data, rather than practical recommendations) means that they do not lend themselves to brief accessible explanations. Furthermore, the findings could readily be construed as critical of staff; thus there is a strong possibility that feedback would not constitute an effective way of thanking or rewarding participants for their role in the research.

Secondly, are the characteristics of both participant groups: residents and staff. People with severe learning disabilities may struggle to understand information that is abstract and relates to things not in the immediate environment. I believe that it would not be possible to present my research findings in a sufficiently accessible way for the residents to gain any useful appreciation of them. To an extent the same could be said for the staff. Interviews with staff revealed that generally their reflection on practice was relatively superficial. The strengths of the staff group lie in their practical orientation to their work, not in their interest in theoretical concepts. The final reason was pragmatic; the duration of the project was considerably greater than I had planned. I had a baby and also moved away from the

city after the period of fieldwork was completed, so maintaining field relationships was not possible, particularly given staff turn over. To re-establish these relationships (or to establish relationships with different staff members) was not feasible. It was therefore decided with regret that feedback to participants would not be included as a component of the project.

Critique of Critical Discourse Analysis

I now move on from specific issues to do with my own research, to reflect on CDA and its application to my data. As discussed in Chapter 2: Literature Review, a major criticism of CDA is its bias i.e. data are selected to support its political commitment (Wodak and Meyer 2001, from Widdowson 1995). This is unarguable; but I have attempted in my analysis to offer alternative interpretations throughout, and indeed there have been many examples that have not supported an assumption of residents being powerless compared to staff. The results of this project are a product of work that was carried out with certain individuals at certain times and places; if this work were to be replicated by others, or even repeated by me at a later date and in a different place, the results may be different. Nevertheless, this does not mean that my findings are not valid, merely that they must be seen as only one possible set of alternative interpretations.

One of my objectives was to explore whether CDA could usefully be applied to interactional data from people with very limited communicative competence. This was challenging. CDA has been applied primarily to linguistic data; Fairclough (2001) does not exclude non-verbal aspects of discourse, such as facial expression

and gesture. However, these are viewed as supplementary to spoken discourse and either help its interpretation or may stand alone if conventionalised e.g. the head nod. What Fairclough's version of CDA does not encompass is the highly idiosyncratic and predominantly non-verbal interaction typical of some of my participants.

A broader question remains as to whether CDA adequately encompasses issues of competence. It addresses issues of knowledge and expertise relating to specific discourses e.g. that used by the legal or medical professions, but the assumption is that individuals have the potential to achieve competence in such domains, given the right societal and institutional conditions. As discussed in Chapter 2: Literature review, mainstream conceptualisations of communicative competence, such as that of Saville-Troike (2003), have been found to be inappropriate for individuals using AAC. Similarly people with severe learning disabilities are perhaps unusual in not necessarily having the same potential as others at an individual level. Nevertheless, given the selective use of analytical tools, in combination with the critical stance that CDA brings, I conclude that this was a useful approach to take.

Further research and possibilities for change

According to Ng and Bradac (1993), the relationship between language and power is complex and can be conceptualised in a number of ways, the primary positions being that language creates power and that language reflects power. In other words, influence occurs in two directions and both processes occur simultaneously in most

instances, but not necessarily to the same extent. This conceptualisation is echoed by Fairclough (1992b) who described the dialectical relationship between discourse and society. It has already been noted that most research and practice within the field of AAC does not appear to assume such relationships. Below, I reflect on the implications of recognising power within future research and intervention, which is aimed at promoting AAC use and of communication in general involving people with learning disabilities.

I start by considering the relatively powerless place of people with learning disabilities in society, and its relevance to our understanding of the problem of AAC non-use. Shakespeare (2000) describes help recipients (such as people with disabilities) as an oppressed group. He suggests four dimensions which contribute to the processes by which disabled people [sic] are stereotyped or seen as 'other' by the rest of the population, some of which were evident in the interaction within my research sites. First is the polarization between helper and helped, normal and abnormal. Examples of this were residents being described by staff as *clever, not daft, not stupid, good, crafty….* Although many of these words have positive connotations, the fact that staff are permitted to make such evaluations is indicative of their power. Such comments are based on presumptions of the lack of these positive attributes: they are notable exceptions to the norm. Lupton and Seymour (2003) frame this argument in terms of the "several resonant and recurring binary oppositions in text and talk that constantly serve to position people with disabilities as Other and as deficient. These oppositions include: normal/freakish, capable/helpless, strong/weak and whole/damaged" (p248).

Shakespeare's second dimension is of disabled people stereotyped as being unable to speak up for themselves. Although the advocacy movement is challenging this (Barnes 1990), I found extremely narrow interpretations of such concepts. At Bungalow A, a 'Self Advocacy Skills' sheet was left largely blank, containing only a few examples of where Claude and Mary had made choices between *'tea or coffee'* and *'beads or magazines'*.

Third is the infantilization of disabled people, by which they are seen as vulnerable, incapable, asexual, and unable to make their own decisions. I found evidence of this in the ways in which staff talked to residents: they often used exaggerated tone of voice, employed vocabulary such as *doggie*, and were generally directive. Such features were not exclusive to staff: Mrs Hughes, Hilary's mother referred to herself as *mummy* to Hilary. Residents were also compared to unruly children, as this excerpt of discussion with staff shows:

> *Cheryl:…Because she's crafty, and Henri is. Really crafty.*
> *Stephanie: is it to do with knowing the rules…?*
> *Cheryl: it's knowing who you can get away with it and who you can't.*
> *Rula: it's a bit like children in a sense*
> *Cheryl: yeah, they're like children.*
> *Rula: like, they know who they can… how far they can take say mum and dad; you know what I mean? They know who they can push their luck with.*
> *Cheryl: they can get round nanny.*

Shakespeare's fourth dimension by which disabled people are seen as other, is a view of them as dependent, as a burden and a problem. This was not particularly evident in my data, and staff views may differ from those of wider society, along this dimension.

While Shakespeare's (2000) discussion of oppression was set in the context of wider society, my examples were drawn from discourses within the institution of care home practice. Shakespeare draws attention to the ambiguity within such care relationships, and the implications this has for the role of people with disabilities. According to Shakespeare (2000), the notion of caring rests on maintaining the cared-for person in a position of dependency and helplessness. The result may be tendencies to control the help recipient. However, Shakespeare (2006) also pointed out that for many people with disabilities, not only practical assistance but also companionship is an important aspect of the care relationship; this may be particularly so for those experiencing the relative social isolation that often accompanies de-institutionalisation. It certainly appeared true of the relationships I encountered; whatever the shortcomings of the interaction between staff and residents, staff provided most, if not all of the social contact for most of the residents.

Such ambiguity within care relationships may point to potentially fruitful areas of research. Ng and Bradac (1993) refer to the 'fluidity' of the social context: if there is sufficient fluidity, interaction will influence existing power hierarchies. Similarly, Diamond (1996) suggests that power is consensual and therefore open to negotiation through discourse; a less powerful participant in an interaction has strategies available to contest the power held by the more powerful person. In this particular context however, any social fluidity is constrained by the nature of the disabilities experienced by residents: these disabilities are not entirely socially constructed but also have "an ontological reality" (Klotz 2004, p98). To a significant extent, my data demonstrate that residents may not be able (in

Diamond's terms) to reject the roles assigned to them, although they may on occasion refuse to ratify the power claimed by staff by virtue of their status within the institution of the residential home. Behavioural non-compliance, often exhibited by Hilary (in Excerpt 2 for example), could be conceptualised in this way. Nevertheless, further research is warranted to explore in greater detail the extent to which the circumstances of limited communicative competence pertaining to people with severe learning disabilities means that these individuals may not have the strategies available to access power held by others.

Another direction for research could involve participants taking part in Critical Language Study (Fairclough 1992a), which "highlights how language conventions and language practices are invested with power relations and ideological processes which people are often unaware of" (p7). Such study contributes to the consciousness raising necessary for challenging linguistic domination, with the aim of achieving "emancipatory discourse practices". Emancipatory discourse aims for greater freedom and respect for all people (Janks and Ivanic 1992). In an ideal world, the critical language awareness of society as a whole would be addressed, thereby reducing the oppression of people with disabilities referred to by Shakespeare (2000), and more specifically the linguistic domination identified by Fairclough (1992a). A more modest aim, which may be of benefit, would be to consider levels of awareness amongst personnel involved at all levels of service provision, including care staff themselves.

Raising the critical language awareness of care staff would build on an existing strand of research in the fields of learning disabilities and AAC, that of staff

training. Ager (1991) found that staff training is often ineffective in producing long term change, although sensitivity to existing staff values and attitudes within the training makes a difference. Likewise, Mendes and Rato (1996) claim that it is changes in attitudes which are necessary for the communication strategies taught to be applied. The combination of the traditional approach of training in specific interaction strategies, with participation in a programme of Critical Language Study would constitute an interesting line of research, primarily involving care staff.

Regarding the residents, since they have substantial learning disabilities, it seems unreasonable and unrealistic to expect them to take responsibility for acquiring the prerequisite consciousness to enable them to challenge or create oppositional or alternative positions (Fairclough 1992) towards the discourses in which they participate. The societal discourses regarding disability described above (which are strongly echoed at the level of the institution and are evident within my data) are ones in which people with disabilities themselves also participate. Shakespeare (2006) says that "People who have been institutionalised all their lives may not have a strong sense of individuality or autonomy. In general, disabled people may have internalised negative messages from significant others, or from society in general, and believe themselves to be incompetent or invalid or undesirable" (p177). The same point is made more generally by Saville-Troike: "Stereotypes which the dominant group in a society holds toward subordinate groups, on the other hand, are often adopted by those groups as part of their own self-image" (Saville-Troike 2003, p195). In terms of CDA, this is because dominant discourses may become 'naturalised' (in the words of Fairclough 1992, p9) and accepted at face value. Nevertheless, involvement of residents in a process of change could occur through

the provision of AAC; this, in parallel with raising the critical language awareness of staff would be worthy of exploration.

Returning now to the situation of mutual influence between language and power which underlies critical discourse approaches to analysis. AAC research has so far concentrated its attention on language, while failing to address issues of power. Prevailing discourses within the care home setting reflect societal conditions of oppression of people with disabilities, and such patterns of discourse may undermine possibilities for AAC use. By failing to enable people with the most severely limited communicative competence from communicating by augmented, or indeed any means, current power relations are maintained.

We do not yet know how developing participants' critical language awareness could contribute to the transformation of interaction between residents and staff, and what implications it might have for residents' use of AAC. But a much more politically aware research agenda in the AAC research community is required.

Conclusions

The theme of asymmetry has recurred throughout my analysis of the interaction between participants, and has been conceptualised in two ways: asymmetry of the power held by residents and staff, and asymmetry in the communicative competence of these two groups. The complex web of mutual influence between language and power makes it possible both that the introduction of a new mode of communication

(AAC) could transform existing power relations, and that transformations in those power relations could enable the flourishing of AAC. It is already known that provision of AAC is not on its own sufficient to ensure its use, within discourse: existing discourse patterns contribute to the failure of AAC to become a functional and valuable method of communication for people with little or no speech.

In focussing on situations of AAC non-use, what may not be evident from this research project is that there are many people with little or no speech who are successful AAC users and indeed may become dependent on it as their main mode of communication. Alex, whose role as 'proxy' is discussed in Chapter 3: Methodology and Appendix 10, is one such individual. What may distinguish him from the residents in this study is that he does not have severe learning disabilities. In terms of communicative competence, according to Light's (1989) definition for AAC users (Chapter 2: Literature Review), Alex would rate as highly competent. In contrast the participants with severe learning disabilities would not necessarily be able to demonstrate sufficient competence in AAC use to be able to take responsibility for the success of communication. The resultant dependence upon others may make them particularly vulnerable to the power relations operating within interaction in which they participate. One of the ways this may be manifested is in the constraints that (more powerful) others place on interaction, which facilitate immediate interaction, but in the process, inhibit AAC use.

It is not realistic to expect that successful AAC use would eliminate power asymmetries, even when it appears to have had a transformatory effect on power relations between the user and those who care for that individual. For Ralph

(Brewster 2003), there was evidence of disempowering societal discourses of disability within his AAC systems and care staff's interaction with him through this mode of communication.

Power operates through all levels of discourse: at the individual level of interaction, at an institutional level and at a societal level. Diamond (1996) emphasises the consensual nature of power at the first of these levels. She explains that power is accessible to participants through competence in such micro-level features of discourse as taking the floor, holding it for long periods, being listened to and agreed with. I have suggested that although my data exhibit examples of residents achieving success in such ways, this is not necessarily accompanied by their gaining power, because this success is reliant on staff making concessions. Examples of such concessions made by staff to residents include not always expecting a resident to follow the usual conventions of politeness, turn taking or topic control, or permitting these conventions to be breached. These concessions could be seen as a response to the (perceived) lower levels of communicative competence of the residents, acknowledging that interaction often has to be on the terms of the residents for interaction to be successful. A more critical interpretation would see this as a strategy involved in power struggle: that staff are "tactically yielding some ground in order to be able to pursue a longer-term strategy" (Fairclough 1989, p69) i.e. staff avoid the use of overt markers of power in order to retain control at an institutional level. For example Hilary's key worker Michelle allows her some latitude in order to contain her behaviour which can often be 'challenging'. Ng and Bradac (1993) describe the above process as one of depoliticisation in which

attempts at influence are camouflaged so as to make them more palatable to the recipient who is therefore less likely to respond with resistance.

The field of AAC research and practice continues to address issues of communicative competence while overlooking the power dimension within discourse. This investigation represents an attempt at bringing a critical dimension to the analysis of interaction involving participants with little or no speech.

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APPENDIX 1: THE RESEARCH SITES

The majority of residents were resettled into their current homes 3-5 years ago, during the programme of closure of the large hospitals which previously housed very many people with learning and other disabilities.

The three homes used in **Phase 1** (September 2003 to May 2004) were:

Long Lane: an adapted bungalow in a well to do residential suburb of the city. The four residents are men identified as having social care needs. No individual residents were selected as suitable for specific focus, and fieldwork was discontinued in January 2004.

Bungalow A: one of seven purpose built bungalows, on the site of a now closed large hospital for people with learning disabilities. The five women and one man living here are categorised as having both health and social care needs. Two residents were selected for specific focus, **Mary** and **Claude**.

Number 32: one of a pair of purpose built bungalows in a bustling residential area. The five women and one man living here are categorised as having health care needs. **Sarah** was selected for focused data collection.

In addition, **Phase 2** (July and August 2004) of data collection took place at:

Bungalow B: next door to Bungalow A. Between Phases 1 and 2 of data collection, administrative reorganisation resulted in A being designated solely as catering for health care needs, and B for social care needs. This brought about **Mary**'s move from A to B, to which I followed her.

Number 34: next door to 32, and run in the same way; it accommodates five women, with similar care needs as in 32. **Hilary** received particular focus.

APPENDIX 2:

CONSENT FORM TO BE FILLED IN ON BEHALF OF RESIDENTS

An investigation of the communication between non-speaking adults with learning disabilities and their carers.

This form is to be filled in on behalf of residents who may find it hard to give clear informed consent. Please involve a family member, carer and anyone else who knows the resident well and who can make a judgement about the resident's views.

Before completing this form, make sure the resident has understood, as far as possible, the Information Sheet about this study.

Remember:

- they can withdraw from the whole study at any time
- they can ask me not to observe or videotape them at any time
- they can ask me not to interview them at any time
- taking part in this study will not involve doing anything they are not happy doing
- if they decide not to take part this will not affect the care they receive in any way.

Please tick any of the following which apply:

The resident named below

- ❑ would like to take part in this study
- ❑ agrees to be observed and for written notes to be made
- ❑ agrees to be videotaped
- ❑ agrees to be interviewed

Please fill in:

Resident's
name…….
Today's
Date……..

Below are spaces for the signatures of all those involved in helping decide if the resident wishes to participate in the research.

Please add as many signatures as appropriate:

Witness's name.
…… .
Witness's
signature……...
Relationship to
resident…….

Witness's name.
…… .
Witness's
signature……...
Relationship to
resident…….

Witness's name.
…… .
Witness's
signature……...
Relationship to
resident…….

Witness's name.
…… .
Witness's
signature……...
Relationship to
resident…….

If you have any questions, please contact me:

STEPHANIE BREWSTER, phone [number given]

Please return the form to me, even if this resident does not wish to take part.

Thank you.

APPENDIX 3: INFORMATION SHEET FOR RESIDENTS

[Not available in this web version]

APPENDIX 4: TRANSCRIPTION CONVENTIONS

Multimodal transcription

The multimodal transcription of interactions recorded on video are discussed in detail on p90, with particular discussion about layout. The following symbols have been used throughout:

→ looks towards

← looks away

► points towards

(n) unintelligible speech (number of syllables, or suggested interpretation)

Merged cells denote continuing behaviour. Non-verbal behaviour is described verbally, while verbal communication is transcribed orthographically.

Audio transcription

Interviews and interactions that were transcribed contemporaneously or audio recorded follow predominantly standard use of punctuation and spelling, where this assists readers' interpretations.

[Author's comments]

Italics are used to signal that the words of others are being quoted, *whether they are embedded* in the body of text or in an indented block, for example:

Stephanie: have you known Gloria a long time?
Claude: yes. In the hospital together… round the corner.

(n) unintelligible speech. (number of syllables, or suggested interpretation)

[single square brackets denote overlapping talk and simultaneous turn beginnings, as in:

Steph: does that mean ['yes'?
Cheryl: [plane.

APPENDIX 5: DATA CODES – DEFINITIONS AND MIND-MAP

Methodology

Gaining entry: initial and subsequent access to the homes and to the people and activities within the homes.
Field relationships: my relationships with participants
First impressions: my first impressions on entry to the home, and staff's first impressions of the homes and residents when they first worked here.
Participant involvement: in data collection
Consent: participant consent to being observed, interviewed, tape recorded and videoed.
Feeding back: how data and research findings are fed back to participants.

Care home practice

Domestic/practical: issues to do with the running of the home
Physical environment: of the home itself, for example furniture arrangement, décor.
Management: of staff, financial concerns, management of the homes.
Roles: this code has two interpretations: formally, staff roles pertaining to their job and informally, resident roles in the home regarding their relationships with others.
Responsibilities: of the staff, in their jobs.
Relationships: between staff, between residents, and between staff and residents.
Care needs: the physical care needs of the residents

Power

Control: implicit control being exerted by staff over situations or clients, usually verbally.
Behaviour management: specifically, the professionalised discourse of behaviour management and challenging behaviour.

Discourses

Responses to difference: any reactions (of the general public and of staff and others) to the residents apparently being seen as different.
Professional recommendations/wider learning disability discourses: often revealed in documentation but also in conversation with staff; ways of talking that relate to caring for people with learning disabilities.
Individual staff discourses: staff beliefs regarding their jobs and the residents.
House discourses: ways of doing things and talking about activity that appears specific to a particular home.
Choice: one particular professional discourse, singled out as of particular relevance.
Conflict between: conflict between competing discourses e.g. between providing choice of foods, and ensuring the residents eat a balanced diet. Also used for any type of conflict or ambiguity between roles and responsibilities.

Interaction

This theme consists of two levels. The first level is general, and the second is more specifically about styles of interaction.

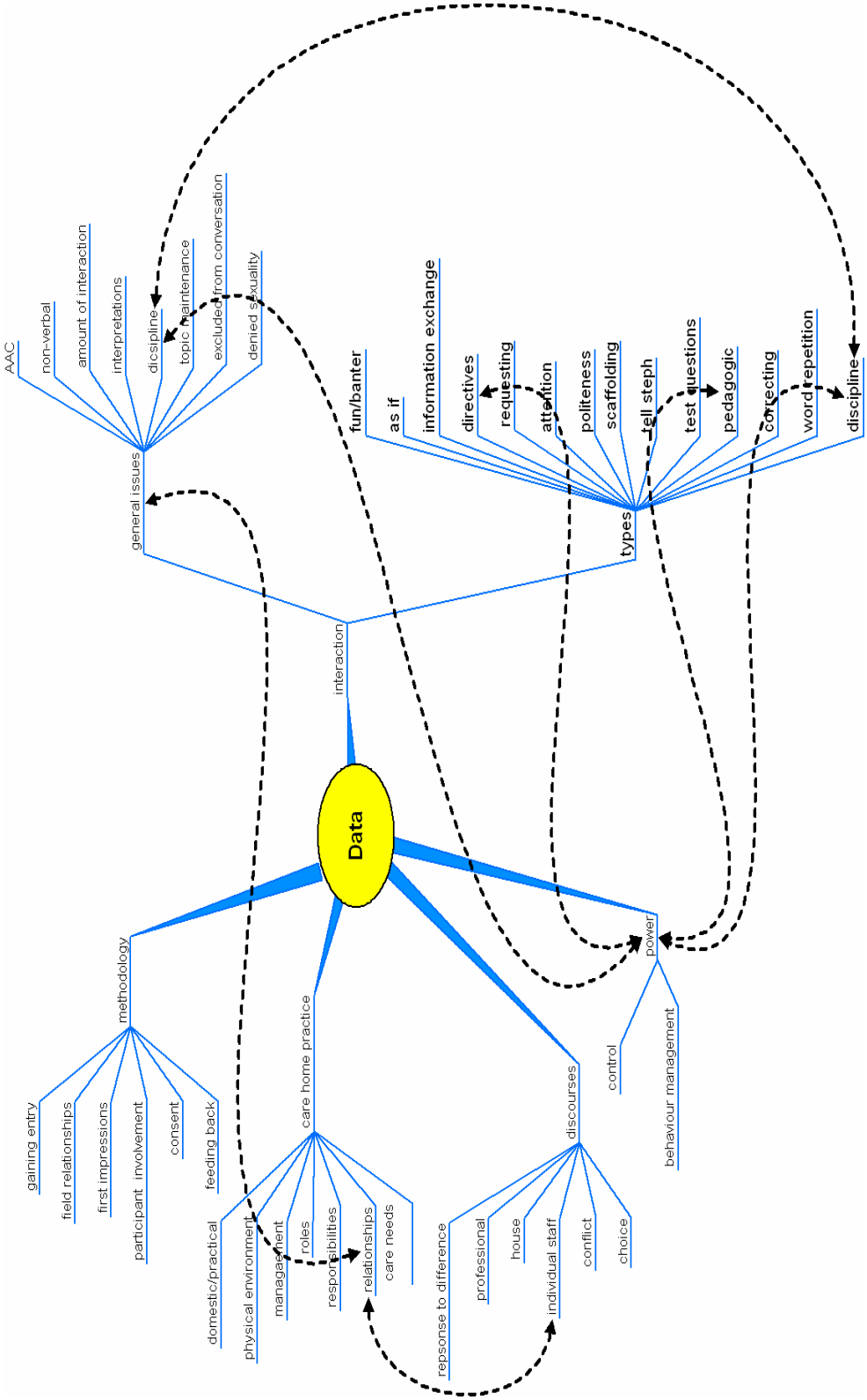
Interaction- general issues

AAC: augmentative and alternative communication, both aided (e.g. use of graphic symbols and devices) and unaided (e.g. use of signing).
Non-verbal: non-verbal behaviour that is interpreted as communicative.
Amount of interaction: including but not limited to instances of apparent lack of interaction with residents.
Interpretations: the interpretations of both staff and residents' interaction, and instances of discussion around issues of interpretation.
Topic maintenance: who introduces, maintains and changes topics in an interaction.
Excluded from conversation: when people (especially staff) hold conversations that the residents are unable to participate in.
Denied sexuality: when a staff member talks about or to a resident as if they are asexual, or it is assumed they are unable/not permitted to express their sexuality.

Styles of interaction

Fun/banter: both verbal and non-verbal interaction where the sole purpose appears to be enjoyment.
'As if': interaction in which participants appear to knowingly talk as if something were true: suspending disbelief.
Information exchange: exchange of new information between interactants, either successfully or unsuccessfully.
Directives: communication whose purpose is to direct the behaviour of others.
Requesting: communication whose purpose is to make a request.
Attention: communication in which attempts are made to attract attention; also the amount of attention a resident may receive.
Politeness: issues of politeness and rudeness in interaction.
Scaffolding: interaction in which a less able person is provided with support to enable them to do a task which is just beyond their level of competence.
'Tell Steph': interaction in which a staff member suggests that a resident tells me something specific (either by using these exact words or not).
Pedagogic: interaction in which there appears to be a (usually an implicit) goal of teaching.
Test questions: questions asked by a staff member to a resident, to which the staff knows the answer.
Correcting: when a listener has understood but insists on further attempts being made towards a more standard form.
Word repetition: when a staff member asks a resident to repeat a word, either for the purpose of 'correcting' or for 'fun/banter'- see above.
Discipline: when staff verbally exert discipline over a resident.

Figure 5: data codes mind-map. This shows the branching structure of codes and their groupings, and some of the links between codes that emerged during coding.



APPENDIX 6: FREQUENCY TOTALS OF DATA CODES

In alphabetical order

AAC	114
Amount of Interaction	306
As If	74
Attention	175
Banter/Fun	151
Behaviour Management	104
Care Needs	110
Choice	79
Conflict Between	66
Consent	84
Control	153
Correcting	14
Denied Sexuality	10
Directive	114
Discipline	48
Domestic Practical	148
Excluded from Conversation	50
Feeding Back	37
Field Relationship	94
First Impressions	21
Gaining Entry	14
House Philosophy	139
Individual Staff	124
Information Exchange	134
Interpretations	249
Methodology	40
Management	129
Non Verbal	222
Participant Involvement	30
Pedagogic	66

APPENDIX 7: SAMPLE DATABASE QUERY

N.B. 'Para' refers to the paragraph number within the dataset; in combination with the date, it forms a unique identifier. 'Site' details have been deleted for reasons of confidentiality.

Politeness: Video and transcriptions

Para	Date	Site	Nature of data	Notes
157	26/11/2003		transcription	
158	26/11/2003		transcription	
161	26/11/2003		transcription	
204	12/12/2003		transcription	
233	17/12/2003		transcription	
237	17/12/2003		transcription	
23h	19/01/2004		transcription	
64	04/02/2004		transcription	
172	06/04/2004		transcription	
181	06/04/2004		transcription	
182	06/04/2004		transcription	
184	06/04/2004		transcription	
187	06/04/2004		transcription	
196	06/04/2004		transcription	
145	18/03/2004		transcription	
22	11/03/2004		video	
29	25/03/2004		video	
7	09/03/2004		video	
17	23/03/2004		video	
34	27/04/2004		video	
4	28/07/2004		video	
27	11/08/2004		video	
40	16/08/2004		video	
20	17/08/2004		video	
21	24/08/2004		video	

APPENDIX 8: SUMMARY OF VIDEO DATA

Video review Sheet number	**Location**	**Date**	**Duration**
1	Bungalow A Tape 1	3.03.04	55 minutes
2		11.03.04	36
3		25.03.04	15
4		1.04.04	4
5		15.04.04	20
6		29.04.04	23
	Number 32 Tape 2		
7a		9.03.04	14
7b		16.03.04	10
7c		23.03.04	7
7d		30.03.04	6
7e		20.04.04	12
7f		27.04.04	25
8	Number 34 Tape3	28.07.04	3
9		5.08.04	31
10		11.08.04	22
11		16.08.04	44
12		1.09.04	19
13	Bungalow B Tape 4	20.07.04	18
14		10.08.04	1
15		17.08.04	16
16		24.08.04	9
Total video data			390 minutes (6 1/2 hours)

APPENDIX 9: SAMPLE VIDEO REVIEW SHEET

Video Review Sheet 7a

Venue: Number 32
Date: 9.03.04
Setting : resident Sarah and staff member Mick in bedroom; kitchen;
Selected for further analysis
/ start of filming

Duration (minutes)	**Description of interaction and participants**	**Coding**
/3	M physically and verbally helps S clean bedroom; polishing. M helps S remember my name. S points out 'look' repeatedly. S requests to clean TV.	Domestic/practical Responsibilities; directives; attention;
3	M takes photos of S for portfolio. 'I done it!' S says to me. 'well done' I say. M demonstrates spray. Moves S in chair round room; hand over hand. M leaves to get hoover.	Scaffolding pedagogic
1	S and I talk. S asks my name again; points out what she has cleaned. M returns.	Info exchange.
4	S says 'hey' to get attention to her holding hoover; looks pleased. 'well done' says M. not all audible noise of hoover. M controls where is cleaned.	Attention. Control Directives.
1	M responds in jest to S's sneezes. S says 'push me' re going to kitchen. They leave bedroom.	Fun/banter
/1	S sat in kitchen with drink. She asks for bib which I get. Door bell; 'it's ringing' she says..	Requesting
/2	S demands a stool. I get it. Then wants magazine, cup moved, bib taken away.	Politeness. Directive/ request
6	S does colouring. Little interaction between staff and S. ?struggling to pick up a crayon?	Amount of interaction.
2	I approach and talk about colouring. S talks to staff off screen, about cleaning and photo/video. Repeats herself at length	Attention:
3	'come and do my house'…asks staff. S asks what I'm doing. Door bell: S screeches and we all comment. Laughs. Word repetition. Staff banter offscreen.	As if. Fun/banter. Excluded from conversation.
Total 14		

APPENDIX 10: INVOLVEMENT OF AN AAC USER AS PROXY

The challenges of involving people with learning disabilities and impaired communication are significant and, according to Bersani Jr, (1999) it may sometimes be impossible. His solution is to use a 'proxy'. Traditionally family members, staff or advocates have been asked to act as proxy, but they are nearly always natural speakers; those with similar disabilities would make more authentic proxies. I decided that the involvement of such a proxy would be a useful addition to my research given the anticipated difficulties in accessing the views of participants with learning disabilities and little/no speech.

I chose to invite Alex to be involved in my research, as a proxy. This young man has athetoid cerebral palsy; he has no use of his arms or legs and cannot speak but is a very effective user of an electronic communication aid and does not have severe learning disabilities. He therefore fitted my requirement of having experience of being unable to speak while still being able to generate and communicate potentially sophisticated views. We had known each other for several years, ever since he had approached the communication aid department where I worked, offering his services to help others who might benefit from AAC.

Much of the literature on participatory research with people with learning disabilities (Chappell 2000) discusses the training and payment of participants; neither of these options were available to me, and they were not what Alex wanted either. His motivation was to help other people with disabilities who might benefit from AAC. My initial concerns about the relationship being potentially exploitative were to some extent alleviated, as our relationship developed and there was a degree of reciprocity; Alex would frequently ask for advice and help from me, usually regarding his AAC system, or publicity materials he wanted to produce to promote his services.

The research project was, from the outset, my own, and it was not my initial intention to carry it out along side others (with disabilities) who would have equally influential roles in it. The initial premise was one of me asking Alex for suggestions and advice, which I might or might not choose to follow. I recognised a need to provide information about the research process, about AAC and communication more generally, but never fully resolved how to go about this without exerting too much influence over his own views.

There were occasions when the views Alex expressed did not appear to meet the emancipatory ethos I wished my research to have. One such occasion was when Alex asked me for advice about another resident at his home; they had a communication aid they weren't using, because they were 'lazy'. He wanted to help them to communicate more with it. That AAC non-use is a problem that lies with the individual with disabilities is a commonly held belief amongst carers and others regarding AAC non-use, and can in my view inhibit the exploration of other limiting factors such as the appropriacy of the AAC system and characteristics of the interaction with others. I was concerned that Alex, like the staff, was assuming the problem lay with the individual. Another example was when Alex compared a peer's AAC system unfavourably with his own, because his own device was capable of generating novel messages and the other was not.

I was surprised by Alex's unsympathetic or judgmental response towards these other AAC users and their methods of communicating, but perhaps I should not have been. The exploration of alternative explanations and the examination of one's own assumptions are some of the key research skills that have developed through my participation in the doctoral process; Alex's own skills in this area seemed relatively undeveloped, which should not be surprising given the low educational and social opportunities he has had in life. Furthermore, it is quite possible that Alex's views closely reflect (rather than contrast with) those of the non-disabled population, including all the prejudices and assumptions which I seek to challenge through this research. He is certainly keen to be regarded as intelligent himself, saying "I want to put across that I am a clever guy". He does of course live in a society which values intelligence and autonomy. According to Goffman (1963) "The stigmatised individual tends to hold the same beliefs about identity that we [wider society] do" (p17).

As the examples above illustrate, the involvement of a proxy was not unproblematic, and its value in my project is difficult to assess. Some limitations may be specific to the relationship between Alex and me. Although we both felt this was productive, perhaps it could have been more so. At the time at which Alex's involvement was most active, I was aware of no research literature presenting models of the proxy role. Subsequently, Clegg has addressed this issue (Clegg 2003), proposing that an ethical relationship between proxy and person with learning disability is crucial. While exploring the nature of such a relationship along various dimensions, Clegg does not go on to suggest ways in which a potential proxy might develop the reflexivity necessary for such a relationship to be achieved. While the role of the proxy still seems to be a useful methodological concept in participatory research with people with learning disabilities, it needs further development.

I now realise that the involvement of a proxy could be developed into a doctoral research project in its own right. I did not wish to do this, and so, having not given it the attention it required and having started with probably unrealistic expectations, I am left with a feeling of dissatisfaction. Nevertheless, although Alex's role was not one of correcting my misconceptions, or explicitly suggesting leads that the research could follow, his contribution of providing me with inspiration and stimulation for ideas was valuable and I am grateful to him.